# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
RATE METHODOLOGY/UNBUNDLING
The most significant change between the expiring DD Waiver and the Renewal is the move to utilization of a uniform rate methodology and the unbundling of Day Services. (Appendices C, I and J)

APPLICATION (MODULE 1) 2. Public Input
• Public Input is now gathered via multiple means, including twice-monthly meetings with interested advocates and formal solicitation efforts contracted through the Indiana Institute on Disability and Community. Contracts with self-advocates and family advocates have been established for increased interaction and support to participants and their families.

APPENDIX A
•A-3 Use of Contracted Entities – The operating agency now contracts with another entity for the various functions previously performed by the Bureau of Quality Improvement Services (BQIS). These functions include components of utilization management, discovery and remediation activities. In addition, the mechanisms for overall systems improvement are contracted out. Oversight of the contractor remains in the hands of the BQIS Central Office.

APPENDIX B
• NUMBER OF PARTICIPANTS SERVED: (Appendices B-3-a, I and J) Indiana had projected to be serving 8118 participants by the end of waiver year 5 , largely due to the addition of reserved capacity criteria enabling participants with parents or guardians age 80 or older to receive priority slots. Projections obtained with the help of advocacy groups were over estimated, leaving reserved slots underutilized. Projections for the total number of active participants receiving DD Waiver services at the end of each waiver year follow:
- °Year 1 - 7133
- °Year 2 - 7392
- °Year 3 - 7644
- °Year 4 - 7884
- °Year 5 - 8118

• Reserved Waiver Capacity modifications include the expansion of priority criteria for individuals with aging caregivers. Additional priority criteria have been added for persons wishing to leave a facility but whose normal caregiver would no longer be able to provide their care, as well as for individuals being served in facilities but with a history of

unexplained injuries or documented abuse that has been substantiated by the DDRS and threatens health and welfare. (Appendix B-3-c)

• Selection of Entrants to the Waiver (Appendix B-3-f) is modified to reflect that targeting, acceptance of the slot, and established eligibility for the waiver will result in removal of the participant from other waiver waiting lists.

• Appendix B-4: Medicaid Eligibility Groups Served in the Waiver is modified to include the following additional Medicaid Aid Categories:

-Children receiving Adoption Assistance or Children receiving Federal
-Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act
-Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII)
-Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII)
-Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV)
-Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI)
-Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII)
-Transitional Medical Assistance – Sec 1925 of the Act

• Appendix B-6-a ii: Frequency of Services is modified to reflect a need for services is now required quarterly rather than monthly, providing services are monitored monthly.

• Appendix B-7-a. Procedures under Freedom of Choice has been changed to specify that in Indiana, participation in a Risk-Based Managed Care program (former statement included all "Managed Care" programs) and HCBS Waiver programs are mutually exclusive.

APPENDIX C

° Day Services were unbundled and replaced by Community Based Habilitation – Group; Community Based Habilitation – Individual; Facility Based Habilitation – Group; Facility Based Habilitation – Individual; Prevocational; Supported Employment Follow Along; and Transportation Services.

° New services added include Electronic Monitoring; Facility Based Support; Intensive Behavioral Intervention; Transportation; and Workplace Assistance.

° Service definition modifications were made to Adult Day Services to enable use of the new Transportation Service in conjunction with Adult Day Services; Respite Care to clarify activities allowed and not allowed; to Residential Habilitation and Support enabling each parent, step-parent or legal guardian to provide the service for up to 40 hours per week; to all therapy services to clarify that service delivery to the participant is not appropriate within their educational setting; and to Behavioral Support Services to remove the never utilized Crisis Assistance component of the service.

° Documentation Standards for the components of day services and Respite have been revised.

° Provider qualifications across all waiver services were made more consistent while qualifications for Family and Caregiver Training Supports were modified, enabling other than Residential Habilitation and Support providers to be approved for service delivery.

APPENDIX D

° The service plan development process has been enhanced by an improved Person Centered Planning process and use of a Health and Safety Indicator.

° To improve Risk Assessment and Mitigation, Outreach Services now offer additional training opportunities and Health Assurance Reviews to providers.

APPENDIX F

° The BQIS grievance/complaint system has been modified due to restructuring of the Bureau.

APPENDIX G

° Participant Safeguards section revised to reflect contracting of most major functions of the Bureau of Quality Improvement Services (BQIS).

° Expiring DD Waiver indicated the operating agency's intent to eliminate use of the National Core Indicator Project with replacement by the Participant Experience Survey (PES). However, rather than the PES, the BQIS now utilizes the Comprehensive Survey Tool (CST), reviewing a sample of DD Waiver service plans to assure consistency of waiver Plan of Care/Cost Comparison Budget with the Individualized Support Plan.

° Rather than conducting agency and standards surveys for paper compliance, the BQIS is focused on participant satisfaction with service delivery.

APPENDIX H
° The Bureau of Quality Improvement Services has revamped the responsibilities of the Quality Improvement Executive Council and now uses the BQIS contractor to lead the Mortality Review Committee.

APPENDIX J
° Cost neutrality formulas have been revised due to uniform rates and new services.

° Service utilization projections have been revised in part due to the addition of new services.

# Application for a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

**A.** The **State** of **Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B.** **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Developmental Disabilities Waiver**

**C.** **Type of Request: renewal**

**Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:** 0378

**Amendment Number** (if applicable): 03

**Effective Date:** *(mm/dd/yy)* 10/01/04

**Waiver Number: IN.0378.R02.00**
**Draft ID: IN.06.02.00**

**Renewal Number:** 02

**D.** **Type of Waiver** *(select only one):*

Regular Waiver

**E.** **Proposed Effective Date:** *(mm/dd/yy)*

10/01/09

**Approved Effective Date: 10/01/09**

## 1. Request Information (2 of 3)

**F.** **Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to

individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☐ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
PURPOSE: The Developmental Disabilities (DD) Waiver maximizes available Indiana resources by providing Medicaid Home and Community Based Services (HCBS) to participants who, but for the provision of such services, would require institutional care based upon level of care criteria for an intermediate care facility for the mentally retarded (ICF/MR) or related conditions, the cost of which could be reimbursed under the approved Indiana Medicaid State plan. A waiver of section 1902(a)(10)(B) of the Social Security Act is requested to target waiver services to the select group of participants who are developmentally disabled.

GOAL: To provide opportunities for meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost effective by assisting the person to become involved in the community where he/she lives and works, to develop social relationships in the person's home and work communities, to develop skills to make decisions about how and where the person wants to live, and to be as independent as possible.

OBJECTIVE: To enable eligible Indiana residents having developmental disabilities to be served under the DD Waiver. Annually, about 264 participants will enter services via reserved waiver capacity (priority) at a pace of 22 persons monthly. Up to 240 participants will be targeted from the wait list at a pace of 20 per month, unless priority utilization would exceed the maximum number of unduplicated participants who may be served that waiver year. Early in the new waiver year, Indiana will target from the wait list to refill slots vacated by death or termination at an average of 159 yearly.

During the first waiver year of the renewal (10/01/2009 to 09/30/2010), Indiana is projecting 504 new participants will be added to the waiver. After lapses, an average net growth of 252 slots per waiver year is expected, the end of year participants are estimated to total:

7133 participants by 09/30/2010.
7392 participants by 09/30/2011,
7644 participants by 09/30/2012,
7884 participants by 09/30/2013, and
8118 participants by 09/30/2014.

Typically, a DD Waiver applicant will also apply for services under two additional Indiana Medicaid HCBS waiver programs operated by the Division of Disability and Rehabilitative Services (DDRS), the Autism Waiver and the Support Services Waiver, in order to be served at the first available opportunity. All three waivers utilize the same DD eligibility and ICF/MR Level of Care requirements, but a participant may only be enrolled, and services may only be received, under one waiver at a time. Upon targeting, acceptance and established eligibility for a DD Waiver slot, the name of the potential participant will be removed from all other Indiana Medicaid HCBS waiver program waiting lists.

ORGANIZATIONAL STRUCTURE: While Indiana's Family and Social Services Administration's Office of Medicaid Policy and Planning (OMPP) is the single state Medicaid agency having administrative discretion in the administration and supervision of the waiver, issuing policies, rules and regulations related to the waiver, the DDRS is responsible for the day-to-day operations utilizing the Bureau of Developmental Disabilities Services (BDDS) and the Bureau of Quality Improvement Services (BQIS) toward that end.

The BDDS Field Offices are responsible for determining initial eligibility for participation in the waiver program. The BDDS Service Coordinator (SC) conducts the intake of each applicant into the state system by completing applications for services, determining if the applicant's disability qualifies as a developmental disability (DD) per the state definition, and whether or not that applicant requires ICF/MR Level of Care. The SC places names of eligible applicants on the waiver waiting list(s) unless criteria is met for a priority slot.

Once the participant is targeted, the SC updates information verifying that the DD eligibility and Level of Care requirements are met, and then refers the person to the contracting entity performing Case Management functions. The contractor is responsible for the Person Centered Planning process, assisting the participant to identify members of the Individualized Support Team, and developing an Individualized Support Plan prior to developing and submitting to the State, the service plan known as the Plan of Care/Cost Comparison Budget (CCB). The CM also assists the participant in obtaining the required eligibility status under Indiana Medicaid or verifies that the participant already has the correct status. The contractor is responsible for submitting and monitoring timelines for annual CCBs and 90-day quarterly reviews, as well as conducting and monitoring the annual redetermination of Level of Care, and compliance with DDRS, BDDS and BQIS policy and procedure.

The BDDS Central Office Waiver Unit reviews each Initial, Annual, and Update CCB, issuing decisions via a Notice of Action (NOA) to the Case Manager and identified providers of waiver services. The Case Manager must provide a copy of the NOA to the participant and/or the participant's legal guardian.

The BQIS is responsible for the development and implementation of quality improvement and quality assurance initiatives, including Incident Reporting, Standards Surveying, QA committee structure and Complaints/Investigations.

SERVICE DELIVERY METHODS: Traditional service delivery methods will be utilized while incorporating as much flexibility as possible within the delivery of services. Prospective providers must attend a provider orientation before obtaining an application and submitting a proposal to become an approved provider of waiver services. Providers of waiver services must first be enrolled as BDDS approved providers with the state's Medicaid system, Indiana Health Coverage Programs, prior to being authorized to provide waiver services.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-

based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to

the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B.** **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

**C.** **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D.** **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E.** **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F.** **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G.** **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H.** **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I.** **Public Input.** Describe how the State secures public input into the development of the waiver:
Input is not limited to the waiver renewal, but is encouraged throughout the year for continuing input to the State. Public input regarding Indiana's waiver program, including the Developmental Disabilities Waiver is obtained through the following activities:

The Division of Disability, Rehabilitative Services (DDRS) Executive Management Team holds twice-monthly meetings with the “Advocates”, an organized group consisting of leaders among the service providers (Indiana Association of Rehabilitation Facilities, Inc "INARF"), the contracting case management provider, behavioral clinicians (Indiana Association of Behavioral Consultants "IN-ABC"), and advocates (Arc of Indiana) addressing concerns and suggestions on behalf of the group and the participants each represents in regard to DDRS program policy and operations.

The DDRS issues quarterly policy bulletins in a draft format inviting public feedback during a 30-day comment

period prior to the release of all waiver-related bulletins with the final approved by the Office of Medicaid Policy and Planning (OMPP).

The Bureau of Developmental Disability Services (BDDS) hosts quarterly provider meetings within each of its eight statewide districts and meets with participant providers. The BDDS also maintains an electronic helpline (manned by one dedicated staff member) and available 24 hours daily, serving as a source of answering general questions and as a receptor of suggestions and ideas from any interested party. Responses are generally within one working day.

The DDRS holds public forums and Webinars as needed toward the dissemination of program or operational changes surrounding the Objective Assessment System for Individual Supports (OASIS) system as it currently exists as well as toward desired changes. The DDRS also maintains an electronic helpline dedicated to addressing questions surrounding the OASIS and/or the Inventory for Client and Agency Planning (ICAP).

Since July 1, 2007, the DDRS has contracted with the Arc of Indiana (Arc) to serve as an extension of the Division. The Arc employs ten "self-advocates" as well as ten "family advocates" (family members) from among the total population of participants with developmental disabilities served within Indiana. The Arc in conjunction with DDRS educates and trains each advocate before forming teams of advocates, Arc personnel, and state staff within each of the eight BDDS Districts. Teams focus on the provision of statewide support to both participants and family members as they conduct a variety of training, development, outreach, assistance, promotion and follow up tasks in addition to measuring customer satisfaction through surveys. Tasks and reporting requirements are specified within the contract.

The DDRS hosts a monthly DDRS Advisory Council meeting as established within IC 12-9-4 and consisting of the Director of DDRS and ten other participants with knowledge of or interest in the programs administered by the Division. All ten are appointed by the Secretary of the Indiana Family and Social Services Administration and represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and OMPP, as well as other Bureaus within the Division; including First Steps, Vocational Rehabilitation, and the BQIS. The mission of the DDRS Advisory Council is to recommend strategies and actions that will ensure DDRS empowers people with disabilities to be independent and self-sufficient.

Prior to this renewal, the DDRS and OMPP sought public input on how to improve the ways participants and their families are served as well as ways to heighten person-centered principles in the architecture of Indiana's waiver service delivery system. In addition to partnering with a group known as the Meaningful Day, the Indiana Institute on Disability and Community (IIDC) was enlisted to assist in this goal by soliciting feedback from stakeholders across the State about how the existing waiver system is or is not meeting their needs.

The IIDC hosted Community Conversations in three cities: Indianapolis (Central Indiana), New Albany (Southern Indiana), and Fort Wayne (Northern Indiana). Each Community Conversation consisted of a two-hour meeting in the evening for people with disabilities, families, and advocates, followed by another two-hour meeting the next day for providers and other professionals in the area. The Community Conversations were open to "all comers," and extensive publicity was disseminated about the invitation. They were publicized in various ways, including newspapers, radio stations, e-mail notices, and announcements releases from organizations serving constituents with disabilities. In all, 197 participants participated in the Community Conversations.

The IIDC invited knowledgeable and leadership participants to participate in focus groups, including professional organizations such as INARF and ICEARC, among whom there were 14 Executive Directors from service providers; The Arc's Family Network Leaders and Self-Advocates, and Indiana's contractor of case management services, involving a total of 27 professionals.

A statewide online survey was used to complement the Community Conversations and Invited Focus Groups to give all interested parties in Indiana an opportunity to share their concerns and suggestions for the waiver re-write process. In a one month time frame, a total of 432 individuals responded to the survey.

In total, 656 individuals participated in the various public input opportunities to address: What's Working; What's Not Working; Concerns and Suggestions about Current and New Waiver Services; and Concerns and Suggestions about Processes and Procedures.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Myszak
**First Name:** Tracy
**Title:** Program Director - DDRS Liaison
**Agency:** Indiana Family & Social Services Administration, Office of Medicaid Policy and Planning
**Address:** 402 W. Washington St., Room W374 (MS07)
**Address 2:**
**City:** Indianapolis
**State:** **Indiana**
**Zip:** 46204-2739
**Phone:** (317) 232-7930 **Ext:** ☐ **TTY**
**Fax:** (317) 232-7382
**E-mail:** tracy.myszak@fssa.in.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Shields
**First Name:** Adrienne
**Title:** DDRS Deputy Director
**Agency:** Indiana Family and Social Services Administration, Division of Disability and Rehabilitative Services
**Address:** 402 W. Washington St., Room W451 (MS26), PO Box 7083
**Address 2:**
**City:** Indianapolis
**State:** **Indiana**
**Zip:** 46207-7083
**Phone:** (317) 232-1147 **Ext:** ☐ **TTY**
**Fax:** (317) 232-1240
**E-mail:** adrienne.shields@fssa.in.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and

certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

| | |
|---|---|
| **Signature:** | Pat Casanova |
| | State Medicaid Director or Designee |
| **Submission Date:** | Sep 10, 2009 |

| | |
|---|---|
| **Last Name:** | Casanova |
| **First Name:** | Pat |
| **Title:** | Director of Medicaid |
| **Agency:** | Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning |
| **Address:** | 402 W. Washington, Room W374 (MS07) |
| **Address 2:** | |
| **City:** | Indianapolis |
| **State:** | **Indiana** |
| **Zip:** | 46204-2739 |
| **Phone:** | (317) 234-2407 |
| **Fax:** | (317) 232-7382 |
| **E-mail:** | pat.casanova@fssa.in.gov |

## Attachment #1: Transition Plan

Specify the transition plan for the waiver:

It is the goal of DDRS to create a system that is both fair and equitable.

Since January, 2009 DDRS has been transitioning participants served under the existing DD Waiver from their previous per diem amounts for Residential Habilitation Services and bundled Days Services to services utilizing only hourly, uniform rates. Residential Habilitation Services are now billed based upon staff hours, while the previously bundled Day Services have been replaced with an array of discrete services, now billed based upon the participant's service utilization.

This renewal includes those discrete services:

1.Residential Habilitation – once a flat per diem, is now a discrete service with an hourly uniform rate

2.Day Services – once bundled into a flat per diem, is now comprised of the following discrete services, with each discrete service having a unique hourly uniform rate:
a.Community Habilitation – Individual
b.Community Habilitation – Group
c.Facility Habilitation – Individual
d.Facility Habilitation – Group
e.Pre-Vocational Services
f.Supported Employment Follow Along
g.Transportation

These same discrete services are contained within this renewal, and in fact, additional services are being requested for approval.

To transition participants to the uniform rates during the current DD Waiver, participants have been allowed to purchase discrete services at the time of their annual renewal (anniversary) date using their currently approved total annual budget amount for these services. The DD Waiver participant continues to complete the Person Centered Planning process and, in conjunction with the participant-selected Individualized Service Team (IST), continues to develop an Individualized Support Plan (ISP). With agreement of the IST, and corresponding to the ISP, the participant may choose to include any combination of the above listed discrete replacement services in addition to any other DD Waiver services desired by the participant in the development of his/her service plan. This transition process will be completed by Sept 30, 2009, prior to the renewal date, for all current waiver participants.

These replacement services offer the same, full array of opportunities, options and allowable activities to the participant under this waiver renewal as were previously available under the DD Waiver. The difference lies only in the unbundling of services, the addition of time-limitations to Prevocational Services and Supported Employment Follow Along Services and the expanded opportunities for community access through the new Transportation service.

The limitations under this renewal that previously were not in place under the DD Waiver are included under Transportation Services, Prevocational Services, Supported Employment Follow Along, Workplace Assistance, Residential Habilitation and Support, and Electronic Monitoring services.

•While previously bundled with Day Services and/or Residential Habilitation and Support (RHS), the newly added Transportation Service is limited to two, one-way trips per day for participants using fewer than 35 hours per week of RHS, which includes participants without RHS services.

•As a component of the bundled Day Services under the prior waiver, no limit previously existed for the amount or duration of Prevocational Services. Under the DD Renewal, a participant may only utilize Prevocational Services for a time period of up to one year from the start date of the service as it appears on an approved Plan of Care/Cost Comparison Budget and subsequent Notice of Action.

•As a component of the bundled Day Services under the prior waiver, no limit previously existed for the amount or duration of the Supported Employment Follow Along (SEFA) services. Under the DD Renewal, a participant may only utilize SEFA for a time period of up to 18 months in the same employment setting without the requirement to find a more appropriate employment setting.

•Otherwise, there are no established dollar amount limits associated with the individually listed replacement services of the formerly bundled Day Services. The participant may choose to utilize all, none, or any desired combination or dollar amount of the replacement services listed above, provided the total cost remains within the amount of their currently approved budget.

•For the new service of Workplace Assistance, utilization is limited to those times when the participant is engaged in paid competitive community employment.

•When determined necessary and appropriate by the participant's Individualized Support Team, either the Residential Habilitation and Support service or the Electronic Monitoring service may each be utilized up to 24 hours per day. However, under the renewal, these two services may not be utilized or billed for the same time period.

•The Crisis Assistance component was removed from the previous Behavioral Support Services/Crisis Assistance definition and from the DD Renewal, leaving Behavioral Support Services as a stand-alone service. The Crisis Assistance service was never utilized or billed under the expiring DD Waiver. As always, DD Waiver participants continue to access crisis assistance services through the operating agency's 100% state-funded Crisis Management system. Consideration will be given to submission of a future amendment of the DD Renewal within which the non-utilized Crisis Assistance service may be redefined and replaced with an accessible and effective stand-alone crisis service, available as needed to DD Waiver participants. Finally, there is the ongoing expectation that the most recently approved budget amount assigned to the participant under the expiring DD Waiver will continue to serve as the budget limit when the participant's next, annual renewal plan of care is developed.

Prior to the renewal, and outside of the medical transportation services available under the Indiana Medicaid State Plan, transportation services were previously available only as a component of Day Services, Adult Day Services, or Residential Habilitation and Support Services. Rather than a loss of services, the renewal offers expanded opportunities for community access through the use of the new Transportation service.

Outside of any life-changing events that may affect the participant's Level of Care or eligibility status for Indiana Medicaid, the participant who was eligible to receive waiver services under the existing DD Waiver will continue to be eligible to participate in the renewed waiver. Eligibility criteria remain unchanged. The participant must be found to have a developmental disability as defined by the State, require the level of care necessary for admission into an Intermediate Care Facility for the Mentally Retarded (ICF/MR LOC) and meet eligibility requirements for Indiana Medicaid in an appropriate Aid Category.

In the event that a participant and/or his/her Individualized Support Team, feels that the current annual budget does not afford the resources to maintain health and welfare, the participant may submit through their case manager a Budget Modification Request, which provides up to 180 days of additional funding as the participant develops long term plans to live within his/her current annual budget total.

As referenced in Appendix D and further explained in Appendix F of this application, all participants are informed at least annually and with each Plan of Care update of the opportunity to request a Fair Hearing. The Bureau of Developmental Disabilities Service Coordinator or the contracting case manager provide the participant, potential participant or legal guardian with written instruction in regard to making such a request. State issued decisions regarding eligibility, level of care determination, Medicaid eligibility, and plan of care decisions all involve the release of information to the participant, potential participant, or legal guardian regarding the opportunity to request a Fair Hearing.

As noted above, transition to the new uniform rate methodology has occurred or will occur for all individuals served under the DD Waiver before the effective date of the renewal. The transition to uniform rates begins the process to eventually transition participants to the Objective Assessment System for Individual Supports (OASIS). Meanwhile, to assist DDRS in assessing our system and more accurately identifying the level of need for each individual participant, a separate, independent and objective assessment of each DD Waiver participant is being conducted (using 100% state funds). These independent and objective assessments will assist the State in determining the most appropriate means and timelines for the future implementation of the OASIS model.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   *(Do not complete item A-2)*

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

*(Complete item A-2-a).*

**The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
**Indiana Family and Social Services Administration, Division of Disability and Rehabilitative Services**

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The waiver will be operated by the Indiana Division of Disability and Rehabilitative Services (DDRS), a separate division of the state from the Single State Medicaid agency, the Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP). The OMPP exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the Memorandum of Understanding setting forth the authority and arrangements for this policy is on file at the State Medicaid agency. Memorandums of Understanding are being written for a two year period with the option to renew.

The oversight role of the Medicaid agency toward ensuring that the operating agency performs its assigned operational and administrative functions in accordance with waiver requirements of Medicaid fiscal and quality accountability and audits for developmentally disabled services is as follows:

•Annually, OMPP shall supervise the development of the CMS annual waiver expenditure reports, review the final report with DDRS and identify problem areas that may need to be discussed and resolved with DDRS prior to submission by OMPP.
•Monthly, OMPP shall review Medicaid waiver expenditure reports, after which, any identified problems will be discussed and resolved with DDRS.
•Daily, OMPP, or OMPP's Fiscal Intermediary, shall review, approve and assure payment of Medicaid claims for waiver services consistent with OMPP established policy.
•Ongoing, OMPP shall be responsible for oversight of all waiver activity (including the contract for case management, level of care (LOC) determination, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes) retaining final authority for approval of level of care and plans of care.
•OMPP shall develop and coordinate Medicaid policy for the State of Indiana

•OMPP, or OMPP's Fiscal Intermediary, shall approve and enroll all providers of waiver services
•OMPP shall review and approve Medicaid waiver applications, requests for renewals and amendments, and shall submit applications, renewals and amendments to the United States Department of Health and Human Services to fund community and home based developmental disability services as alternatives to institutionalization.
•OMPP shall seek and review comment from DDRS before the adoption of rules or standards that may affect the services, programs, or providers of medical assistance services for persons with developmental disabilities who receive Medicaid services.
•OMPP will review and approve all waiver manuals, bulletins, communications regarding waiver policy, and quality assurance/improvement plans prior to implementation or release to providers, participant families or any other entity.
•OMPP shall retain final authority for rate setting and coverage criteria for all Medicaid services, including provider rates, the basis for any activities reimbursed through administrative funds, and state plan services provided to waiver participants.

Management teams from OMPP and DDRS meet every other week to review programs, recommend changes and address programming concerns. The performance of contracting entities is reviewed, discussed and addressed as needed during these meetings.

The executive office of the Family and Social Services Administration is also represented at these meetings where programs are reviewed, changes are recommended, programming concerns are addressed and the performance of contracting entities is reviewed, discussed and addressed as needed.

OMPP receives management reports from DDRS, BQIS and the fiscal contractor. These reports include:
- From DDRS, the case management contractor's quarterly management report,
- From BQIS, the quality contractor's quarterly management report which contains aggregate data from the CST reviews, transition reviews, financial reviews, incident reports, mortality reviews and trend analysis, and
- From the fiscal contractor, monthly and quarterly management reports.

The Office of Medicaid Policy and Planning is notified by the operating agency of performance issues. Termination of vendor contract is possible should the contractor be unable or unwilling to meet the expectations of the State.

Additionally, as part of OMPP's oversight authority for assuring that participants' service plans (which include risk plans for identified health issues) are appropriate and effective, OMPP has selected several key health issues to monitor for developmentally disabled individuals. This monitoring is conducted to assure that when individuals have these health issues, that the health issues are identified timely, treated promptly, and that follow-up care is provided. All of this information should be identified in participants' service plans, when it is not, OMPP refers the specific issues to DDRS for appropriate remediation. Specifically these are the health issues that OMPP is monitoring:
- UTIs. OMPP is monitoring that all individuals with UTIs are receiving appropriate treatment.
- Incontinence. OMPP is monitoring that individuals have an appropriate care plan in place.
- Use of anti-psychotic medication. OMPP is monitoring anti-psychotic medication management.
- Preventative care. OMPP is monitoring annual preventative care visits.

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   A contract exists between the State Medicaid agency (OMPP) or the operating agency (DDRS) and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which contracted entities conduct waiver operational functions are available to CMS upon request through the State Medicaid agency or the operating agency (if applicable).

   Specific to the operational and administrative functions of this waiver, the following activities will be conducted

by these contracted entities.

1.The case management contractor is responsible for assisting with participant enrollment activities regarding Medicaid eligibility, conducting annual and ongoing evaluation and determination of level of care, ensuring the proper prior authorization of waiver services and various components of utilization management. Additional duties and responsibilities of the case management contractor are detailed in Appendices C and D.

2.The fiscal agent contractor is responsible for assisting the Office of Medicaid Policy and Planning (OMPP) in ensuring proper prior authorization of waiver services, various components of utilization management, qualified provider enrollment, the execution of Medicaid provider agreements, including all waiver provider agreements; and conducting training and providing technical assistance concerning waiver requirements.

3.The Quality Assurance and Quality Improvement contractor within the operating agency is responsible for various components of utilization management, the discovery and remediation activities conducted for the waiver as well as the mechanisms for overall systems improvement.

4.The Surveillance and Utilization Review contractor is responsible for various components of utilization management functions as well as quality assurance and quality improvement through waiver auditing, incorporated into the Surveillance Utilization Review (SUR) functions of a contract negotiated between the Medicaid agency and selected contractor. OMPP monitoring functions include the reveiw of reprots that indicate audit phases such as planning, field work and final reports. OMPP routinely reviews appeal reports with are stratified by finding, collections, SUR concern line activities, pre-payment review (ppr), new providers, and encourage one-on-one contact with the service providers to ascertain feedback of or contractor's performance.

OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate possible problems. The Contractor submits recommendations for review based on their data.

The selected contractor will construct an audit process that utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and those referred by the state. The member's eligibility for waiver services will be validated. Home visits will be conducted to verify that services billed are authorized in the plan of care, are being delivered, and are meeting the needs of the member.

The OMPP will oversee the contractor’s aggregate data to identify common problems, determine benchmarks, and can provide data to providers to compare against aggregate data. A major focus of the SUR audit exit process will be provider education.

Additionally, it is expected that OMPP staff will periodically accompany the contractor on-site, to observe the waiver services.

Please note: The OMPP is re-procuring the Surveillance Utilization Review (SUR) contract. OMPP is operating the SUR function until it is assured that the contracting entity selected to perform waiver auditing functions can satisfy the deliverables stipulated within the contract.

- ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ◉ **Not applicable**
- ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that

is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
1.The Division of Disability and Rehabilitative Services (DDRS) Case Management Liaison position is responsible for monitoring and assessing the performance of the contracted case management entity and reports directly to the Deputy Director of the Division. The liaison develops an audit report annually that is provided to OMPP. Family and Social Services Administration (FSSA)auditors also conduct an annual financial survey of the case management contractor.

2.The Office of Medicaid Policy and Planning (OMPP), is responsible for assessing performance of the Medicaid Fiscal Agent's provision of training and technical assistance concerning waiver requirements and, in collaboration with DDRS, the execution of the Medicaid Provider Agreements toward the enrollment of Developmental Disabilities Waiver providers approved by DDRS. The contracting Medicaid Fiscal Agent is responsible for provider enrollment. Monthly and quarterly reports are submitted by the contractor.

3.Oversight of the contractor of Quality Improvement Services is monitored by the Quality Vendor Manager employed by the operating agency's (DDRS) Bureau of Quality Improvement Services (BQIS). The Quality Vendor Manager position reports directly to the Director of BQIS. A quarterly managment report is submitted by the quality contractor.

4.The Office of Medicaid Policy and Planning (OMPP) is responsible for oversight of waiver audit functions performed by the Surveillance and Utilization Review (SUR) contractor. OMPP has developed a contreact monitoring report to measure the audit contractor's adherence to the contract and quality of work being performed. OMPP review monthly, quarterly and annual reports summarizing audit activities.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The contracting case management entity is required to comply with all reporting requirements of the State. Reporting and communication between the contractor and the Indiana Family and Social Services Administration's Division of Disability and Rehabilitative Services (DDRS) is managed through the DDRS Case Management Liaison position, dedicated to oversight of this contractor. Assessment methods include weekly teleconferences and monthly meetings

between the Liaison and the contractor's management team; daily, weekly, monthly and quarterly review of multiple reports and data points by the Liaison. When corrective action plans are necessary, oversight to ensure implementation is the responsibility of the Liaison.

Through the review of the various reports, data points and participant satisfaction surveys, the DDRS Case Management Liaison in conjunction with the DDRS Executive Management Committee is able to determine whether or not the contractor is capable of fulfilling the requirements and deliverables of the existing contract.

The OMPP oversees the contracting Medicaid Fiscal Agent's monthly reports of reviews. Oversight of the Fiscal Agent also involves the DDRS/BDDS Provider Relations Specialist position, which oversees and assures that providers are appropriately enrolled through the Medicaid fiscal agent. The required Waiver Enrollments and Updates Weekly Report is sent by the fiscal agent to the Provider Relations Specialist. Providers are to be enrolled by the dedicated fiscal agent Provider Enrollment Specialist within an average 30 days from receipt of the completed provider agreement paperwork. Complaints about the timeliness or performance of the Medicaid fiscal agent are relayed to the OMPP Director of Operations and Systems by the Provider Relations Specialist.

The majority of primary functions of the Bureau of Quality Improvement Services (BQIS) are completed by a contractor. Specifically the privatization vendor is responsible for Quality Monitoring, Incident Review, Mortality Review, Risk Management and Information Technology Development. The BQIS has a full-time, Quality Liaison position dedicated to monitoring this contract. This position uses the following methods to assure that the contractor performs its assigned functions in accordance with contract and waiver requirements:

• The Quality Liaison will meet with the contractor's Project Director and Assistance Project Director on a weekly basis to review and follow-up on outstanding issues.

• On a quarterly basis BQIS receives reports indicating number of comprehensive surveys completed, analysis of findings, and trends identified. The Quality Liaison reviews these reports and follows-up with the contractor when concerns are identified. In addition to analytical reports based on survey findings, the contractor will also submit quarterly reports on their performance.

• On a monthly basis the Quality Liaison will use the automated survey tool to randomly validate any of the performance measures identified in this report. Discrepancies will be brought to the contractor's attention for discussion.

• On a quarterly basis, the Quality Liaison will review a random sample of the survey results for at least 2% of the participants surveyed during the previous quarter. This will confirm for BQIS that the contractor is conducting the reviews that have been reported. The Quality Liaison also validates the sample size.

• Other indicators that the contractor will report on quarterly include Incident Review and Mortality Review. The Quality Liaison will work with the contractor to develop additional performance measures.

Ultimately, the goal of the BQIS is to assure that the state is aware of and has taken appropriate action to assure the participant's health, safety and welfare. The Quality Liaison participates in all risk management meetings and oversees the contractor's interactions with others as well as monitors that it implements assigned tasks.

In order to assure that the contracting entity selected to perform waiver auditing functions under the Surveillance Utilization Review (SUR) contract negotiated by OMPP is satisfying conditions of the contract, OMPP will exercise oversight and monitoring of the deliverables stipulated within that contract. Reporting requirements will be determined as agreed upon within the fully executed contract. Implementation is expected on or before the effective date of the DD Waiver Renewal.

## Appendix A: Waiver Administration and Operation

**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency*

*(1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity |
|---|---|---|---|
| **Participant waiver enrollment** | ☑ | ☑ | ☑ |
| **Waiver enrollment managed against approved limits** | ☑ | ☑ | ☐ |
| **Waiver expenditures managed against approved levels** | ☑ | ☑ | ☐ |
| **Level of care evaluation** | ☑ | ☑ | ☑ |
| **Review of Participant service plans** | ☑ | ☑ | ☐ |
| **Prior authorization of waiver services** | ☑ | ☑ | ☑ |
| **Utilization management** | ☑ | ☑ | ☑ |
| **Qualified provider enrollment** | ☑ | ☑ | ☑ |
| **Execution of Medicaid provider agreements** | ☑ | ☑ | ☑ |
| **Establishment of a statewide rate methodology** | ☑ | ☑ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☑ | ☐ |
| **Quality assurance and quality improvement activities** | ☑ | ☑ | ☑ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Rate of UTIs. Numerator: The total number of waiver participants seen in inpatient or outpatient setting with UTI diagnosis. Denominator: The total number of waiver participants.**

**Data Source** (Select one):
**Analyzed collected data (including surveys, focus group, interviews, etc)**
If 'Other' is selected, specify:
**Claims data**

| Responsible Party for | Frequency of data | Sampling Approach*(check* |
|---|---|---|

| **data collection/generation** *(check each that applies):* | **collection/generation** *(check each that applies):* | *each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Review of Service Plans - Appropriate Care Plans for incontinence. Numerator: The total number of waiver participants with appropriate care plan documentation. Denominator: The total number of sampled waiver participants identified as being**

**incontinent.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Individualized Support Plans**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Prevention Quality Indicator (PQI) Urinary tract infection (UTI) rate. Number of admissions for UTI per 10,000 waiver participant months. Numerator: The total number of waiver participants admitted for UTI during prior 12 month period. Denominator: The total number of months enrolled on waiver.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Claims data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Anti-Psychotic Medication Management. Numerator: The total number of waiver participants who had a visit to a mental health prescriber in the past year. Denominator: The total number of waiver participants identified as being on anti-psychotic medications.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Claims data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| | |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Hemoglobin A1c for all waiver participants on anti-psychotic medications. Numerator: The total number of waiver participants on anti-psychotic medications who received HbA1c test. Denominator: The total number of waiver participants who have been identified as being on anti-psychotic medications.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Claims data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Annual Preventative Care Visit. Numerator: The total number of waiver particpants with a PMP or OB/GYN visit in the past 12 months. Denominator: The total number of waiver participants.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Claims data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Monitoring of participant waiver enrollment - movement of the waiting list. Numerator: The total number of participants actually targeted from the waiting list each month. Denominator: The projected number of participants to be targeted from the waiting list each month.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Targeting report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Medicaid staff (OMPP) meets at least weekly with the operating agency (DDRS)to answer questions, identify areas of concern and resolve issues to ensure the successful implementation of the waiver program. OMPP works with DDRS to ensure that problems are addressed and corrected. These items are documented through meeting minutes between the OMPP and DDRS as well as through the analysis of the data aggregation as outlined in this appendix.

OMPP staff are also active, permanent members on numerous DDRS oversight committees: The Mortality Review Committee, Provider Sanctions Committee, The Community Residential Facilities Council and The Quality Improvement Executive Council.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ○ **Aged or Disabled, or Both - General** | | | | | |
| | ☐ | **Aged** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ○ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ◉ **Mental Retardation or Developmental Disability, or Both** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | ☑ | **Autism** | 0 | | ☑ |
| | ☑ | **Developmental Disability** | 0 | | ☑ |
| | ☑ | **Mental Retardation** | 0 | | ☑ |
| ○ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | |
| | ☐ | **Serious Emotional Disturbance** | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

In regard to specific State policies concerning the reasonable indication of the need for waiver services, as described in Appendix B-1-a of this application, the target groups for this waiver include participants with mental retardation and/or other developmental disabilities, such as cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation. As described in Appendix B-6-d, the basic requirements of the participants condition must be such that the condition had an onset prior to age 22 and is expected to continue, and due to the condition, the applicant for services needs a combination or sequence of services. Indiana further defines developmental disabilities in Indiana Code, specifically IC 12-7-2-61.

In addition to the basic requirements found in IC 12-7-2-61, Indiana also requires that the participant meet at least four of the six substantial limitation categories as defined in 42 CFR 435.1009, are: 1) self-care, 2) learning, 3) self-direction, 4) capacity for independent living, 5) receptive and expressive language, and 6) mobility. These criteria are considered along with the Developmental Disabilities Profile and an array of collateral materials when considering eligibility for waiver services.

These requirements are found within the Bureau of Developmental Disabilities Services' policies for Intake and Assessment as well as the policy governing eligibility determination. The Bureau is reviewing the policy for eligibility determination for potential revision which will occur near the time of the DD Waiver renewal.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

**The limit specified by the State is** *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  *Specify:*

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is** *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  **The dollar amount** *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

  Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

  Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 7370 |
| **Year 2** | 7637 |
| **Year 3** | 7896 |
| **Year 4** | 8148 |
| **Year 5** | 8388 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number

of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

| Purposes |
|---|
| **Eligible individual in other setting whose health and welfare is threatened** |
| **Eligible individuals transitioning to the community from NF, ESN and SOF** |
| **Eligible individuals determined to no longer need/receive active treatment in group home** |
| **Eligible individuals transitioning from 100% state funded services** |
| **Eligible individuals with loss or incapacitation of the primary caregiver** |
| **Eligible individuals with an aging primary caregiver** |
| **Eligible individuals aging out of DOE, DCS or SGL** |
| **Eligible individuals requesting to leave LP/ICF-MR with parent/guardian incapacitated** |
| **Eligible individuals transitioning from Crisis Management and meet certain other criteria** |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individual in other setting whose health and welfare is threatened

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and who are receiving service under the direction of the Division in a supervised group living setting, nursing facility, or large private intermediate care facility and has a history of unexplained injuries or documented abuse that is sustained by the Division and that threatens the health and welfare of the individual.

**Describe how the amount of reserved capacity was determined:**

This new reserved capacity category is added due to the passage of Indiana's Public Law 73-2008. The law states that priority to receive DD waiver services will be given to an individual who is receiving services under the direction of the Division of Disability and Rehabilitative Services (DDRS) in a supervised group living setting, nursing facility, or large private intermediate care facility and has a history of unexplained injuries or documented abuse that is substantiated by the division and that threatens the health and welfare of the individual.

Internal policy and procedure will dictate and more narrowly define severity of injuries or situations of abuse for which this criterion may be applied. As the placement authority, the Bureau of Developmental Disabilities Services will pursue the most appropriate placement for the individual, using the waiver as needed. The DDRS serves an average of 5540 individuals each month within the supervised group living setting, nursing facility, and large private intermediate care facility settings noted above.

Retrospectively, DDRS estimates there have been approximately 14 situations over the past seven (7) years for which an individual would have met this criterion had it existed. Otherwise, persons currently served in a nursing facility may already elect to enter into DD Waiver services via another pre-existing priority criterion. Based on historical data, DDRS projects two (2) waiver slots per year will be utilized for this new reserved capacity category.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 2 |
| Year 2 | 2 |
| Year 3 | 2 |
| Year 4 (renewal only) | 2 |
| Year 5 (renewal only) | 2 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals transitioning to the community from NF, ESN and SOF

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and who are transitioning to the community from Nursing Facilities, Extensive Support Needs Homes, or State Operated Facilities

**Describe how the amount of reserved capacity was determined:**

The projected number of slots to be utilized for this pre-existing reserved capacity category was based upon historic utilization of the category under the expiring DD Waiver. Despite the projected annual increases in the number of participants to be served during each year of the renewal, the historic utilization number was not adjusted.

It is anticipated that the potential need for an increased number of individuals to enter into DD Waiver services via this pre-existing reserved capacity category will be offset by the number of potential participants who enter into DD Waiver services via consistent targeting from the waiver waiting list. Targeting from the wait list will capture a portion of the individuals who might otherwise require priority criterion to enter into DD Waiver services.

The Division of Disability and Rehabilitative Services (DDRS) serves an average of 1624 persons with developmental disabilities in nursing facility settings in any given month. Only about 2% of those persons elect to leave the nursing facility and enter into waiver services over the course of the waiver year. Persons served by DDRS in Extensive Support Needs (ESN) settings rarely elect to leave these settings in order to receive services under the waiver. Historically, of the 64 persons served by DDRS in ESN settings, fewer than 2% of ESN residents per waiver year elect to enter into waiver services via this criterion. This number is not expected to increase.

DDRS also serves an average of 177 persons with developmental disabilities in state operated facilities (SOF) in any given month. Some of these individuals are already waiver participants who require interruption of waiver services for temporary placement in the SOF, then return to waiver services once current issues, such as escalated behaviors, are resolved. Historically, of the 177 persons with developmental disabilities served in an SOF, only about seven (7) persons enter into DD Waiver services each year (for the first time) via this criterion. Therefore, the historic number of participants entering into DD Waiver services annually via all components of this priority category is expected to remain steady at a total of 45 participants per year for years one through five of the Renewal.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 45 |
| Year 2 | 45 |
| Year 3 | 45 |
| Year 4 (renewal only) | 45 |
| Year 5 (renewal only) | 45 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals determined to no longer need/receive active treatment in group home

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and have been determined by the state department of health to no longer need or receive active treatment provided in a supervised group living setting.

**Describe how the amount of reserved capacity was determined:**

The projected number of slots to be utilized for this pre-existing reserved capacity category was based upon historic utilization of the category under the expiring DD Waiver. Despite the projected annual

increases in the number of participants to be served during each year of the renewal, the historic utilization number was not adjusted.

Division of Disability and Rehabilitative Services (DDRS) typically serves an average of 3598 persons with developmental disabilities within Supervised Group Living (SGL) settings in any given month. Less than 1% of these persons seek a priority slot under the DD Waiver due to being tagged by the Indiana State Department of Health as no longer being in need of active treatment/inappropriate placement. Indiana has chosen not to increase the number of licensed ICF/MR beds in the SGL settings, so there is no expectation of a potential increase in the number of individuals who will enter into DD Waiver services via this pre-existing reserved capacity category.

Therefore, the historic number of participants entering into DD Waiver services annually via this priority category is expected to remain steady at two (2) participants per year for years one through five of the Renewal.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 2 |
| Year 2 | 2 |
| Year 3 | 2 |
| Year 4 (renewal only) | 2 |
| Year 5 (renewal only) | 2 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals transitioning from 100% state funded services

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and who are transitioning from 100% state funded budgets onto the DD Waiver.

**Describe how the amount of reserved capacity was determined:**

The projected number of slots to be utilized for this pre-existing reserved capacity category was based upon historic utilization of the category under the expiring DD Waiver. Despite the projected annual increases in the number of participants to be served during each year of the renewal, the historic utilization number was not adjusted.

In 2007 there were 147 transitions from 100% state-funded budgets to waiver services. The number dropped to 98 transitions in 2008 and only 47 transitions were expected to be completed by the September 30, 2009 expiration of the current waiver. With fewer individuals being served by 100% state funded budgets in 2009 than existed in 2007, efforts will continue to transition eligible individuals to DD Waiver services. However, during year five of the expiring waiver, the Division of Disability and Rehabilitative Services has been able to transition individuals from 100% state-funded budgets into waiver services at a pace of just over 5 individuals per month.

Therefore, the projection was made to transition a total of 60 individuals per waiver year from 100% state-funded budgets into DD Waiver services.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 60 |
| Year 2 | 60 |
| Year 3 | 60 |
| Year 4 (renewal only) | 60 |
| Year 5 (renewal only) | 60 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals with loss or incapacitation of the primary caregiver

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and for whom the primary caregiver of the individual is no longer able to care for the individual due to:

(A) the death of the primary caregiver; or
(B) the long term institutionalization of the primary caregiver; or
(C) the long term incapacitation of the primary caregiver; or
(D) the long term incarceration of the primary caregiver.

**Describe how the amount of reserved capacity was determined:**

The projected number of slots to be utilized for this pre-existing reserved capacity category was based upon historic utilization of the category under the expiring DD Waiver. Despite the projected annual increases in the number of participants to be served during each year of the renewal, the historic utilization number was not adjusted. It is anticipated that the potential need for an increased number of individuals to enter into DD Waiver services via this pre-existing reserved capacity category will be offset by the number of potential participants who enter into DD Waiver services via targeting from the waiting list.

Therefore, the historic number of participants entering into DD Waiver services annually via this priority category is expected to remain steady at 50 participants per year for years one through five of the Renewal.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 50 |
| Year 2 | 50 |
| Year 3 | 50 |
| Year 4 (renewal only) | 50 |
| Year 5 (renewal only) | 50 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals with an aging primary caregiver

**Purpose** *(describe):*

To pioritize waiver access to eligible individuals who are developmentally disabled and have a primary caregiver, including a parent who is a primary caregiver, who is :

• Age 80 or older as of 10/01/2009
• Age 78 or older as of 09/01/2010
• Age 76 or older as of 09/01/2011
• Age 74 or older as of 09/01/2012
• Age 72 or older as of 09/01/2013
• Age 70 or older as of 09/01/2014

**Describe how the amount of reserved capacity was determined:**

While the criteria enabling eligible participants entrance into DD Waiver services due to an aging primary caregiver is pre-existent under the DD Waiver, this criterion has been modified. Under the expiring waiver, the aging caregiver providing care to a potential participant with a developmental disability had to reach or exceed 80 years of age prior to the criterion being met. Under the Renewal, the minimum age of the aging caregiver has been lowered by two years of age during each year of the renewal.

Historically, Indiana had not gathered or tracked data regarding age of the applicant's caregiver at the time of application for waiver services. Under the expiring waiver, projections for utilization of this category of reserved capacity were based upon two factors, the age of the applicant whose name appeared on the wait list for DD Waiver services and an estimate of need supplied by an advocacy group. In all, it was estimated that at least 400 participants would enter into DD Waiver services during the first year that this new criterion was applicable. In fact, only 145 new participants entered into services under this criterion during that first year.

In 2009, the pace for entrance into services via this criterion is expected to reach a total of only 47 additional entrants. The prior and significant under realization of prior projections, combined with declining minimum age requirements of the primary caregiver leads to a more conservative projection of 64 new entrants per waiver year.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 64 |
| Year 2 | 64 |
| Year 3 | 64 |
| Year 4 (renewal only) | 64 |
| Year 5 (renewal only) | 64 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals aging out of DOE, DCS or SGL

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and who will be attaining the maximum age for any of the following settings funded by the Indiana department of education (facility, residential); the Indiana department of child services (foster care, facility, residential, group home), or Indiana Medicaid (Supervised Group Living).

**Describe how the amount of reserved capacity was determined:**

The projected number of slots to be utilized for this pre-existing reserved capacity category was based upon historic utilization of the category under the expiring DD Waiver. Despite the projected annual increases in the number of participants to be served during each year of the renewal, the historic utilization number was not adjusted because the number of eligible persons reaching the maximum age for services funded by other sources is not expected to change during the Renewal period.

The Department of Education (DOE) reports a constant number of students annually who are aging out of services funded by the DOE (an average of 25 annually), while the number of students who actually select and qualify for waiver services is expected to remain consistent with numbers previously tracked under the expiring DD Waiver. Only 13 active participants have transitioned from DOE services to DD Waiver services via this criterion.

Until 2009, the exact number of children reaching the maximum age for placements funded by the Department of Child Services (DCS) who then actually selected and qualified for the DD Waiver had not been separately tracked in the expiring waiver. While this number may prove to be variable as data is accumulated, the overall numbers of participants who have entered into DD Waiver services under the combined components of this criterion have not significantly changed from one waiver year to another. Ongoing targeting from the waiting list is expected to offset any significant changes in the number of children who would otherwise require entrance into DD Waiver services via this criterion, even in the event of changing numbers from the DCS.

In addition to ongoing targeting, Indiana's decision not to increase the number of licensed ICF/MR beds in the SGL settings, including the number of beds that may be occupied by children, would imply no expectation of a potential increase in the total number of individuals who will enter into DD Waiver services via this pre-existing reserved capacity category. Therefore, the historic number of participants entering into DD Waiver services annually via the combined components of this priority category is expected to remain steady at 37 participants per year for years one through five of the Renewal.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 37 |
| Year 2 | 37 |
| Year 3 | 37 |
| Year 4 (renewal only) | 37 |
| Year 5 (renewal only) | 37 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals requesting to leave LP/ICF-MR with parent/guardian incapacitated

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and a request to leave the facility is made by a current resident of a Large Private Intermediate Care Facility for the Mentally Retarded, whose parent or legal guardian is incapacitated and no longer able to care for the individual.

**Describe how the amount of reserved capacity was determined:**

This new reserved capacity category is added due to the passage of Indiana's Public Law 73-2008. Residents of Indiana's Large Private Intermediate Care Facilities for the Mentally Retarded (LP ICF/MR) are often admitted due to incapacitation of the primary caregiver, high medical needs of the resident due to multiple disabilities, and/or complex medical needs of the resident that exceed the care-giving capabilities of the family or legal guardian.

In many cases, the resident of the LP ICF/MR is not his/her own guardian. As has been seen when residents of nursing facilities express a desire to leave their facility and enter into DD Waiver services, the legal guardian is often opposed to the request due to the lack of 24-hour nursing services under the waiver program. It has been noted that even for residents who are physically stable and express a desire and/or request to be discharged from the LP ICF/MR, the legal guardian is likewise often opposed to granting a discharge into Home and Community Based Services (HCBS) due to a perceived increase in risk factors when a resident leaves a facility to become a participant in the HCBS waiver program.

As ongoing targeting efforts offer HCBS to a percentage of the 314 residents living in the State's three LP ICF/MRs, those residents whose legal guardians will permit their release may then enter into DD Waiver services via the routine targeting efforts. For those residents who may express a desire for discharge but have no parent or other caregiver willing or capable of providing services, it is anticipated that only as many as two (2) residents per year will enter into DD Waiver services via this criterion as most will not leave the LP ICF/MR.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 2 |
| Year 2 | 2 |
| Year 3 | 2 |
| Year 4 (renewal only) | 2 |
| Year 5 (renewal only) | 2 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Eligible individuals transitioning from Crisis Management and meet certain other criteria

**Purpose** *(describe):*

To prioritize waiver access to eligible individuals who are developmentally disabled and who are transitioning from Indiana's Crisis Management system who have been served for up to and including

120 days- and who meet the following criteria: (1) receive no other Medicaid funded services that provide residential or home-based supports (i.e. the individual does not currently have a 1915(c) waiver and will not return to placement in an ICF/MR group home); (2) are determined by the Division of Disability and Rehabilitative Services Director of Client Services as requiring waiver services in order to successfully transition from crisis service; and (3) have a transition plan in place as developed by the individual, his/her guardian, the crisis team and the identified waiver providers.

**Describe how the amount of reserved capacity was determined:**

The projected number of slots to be utilized for this pre-existing reserved capacity category was based upon historic utilization of the category under the expiring DD Waiver. Despite the projected annual increases in the number of participants to be served during each year of the renewal, the historic utilization number was not adjusted. As the 100% state funded Crisis Management Services system continues to be enhanced and requested by a growing number of service providers, the increasing effectiveness of Crisis Management system is expected to minimize the number of persons served through Crisis Management who are ultimately determined to require waiver services.

Crisis Management services were first implemented in September 2007 and have been available as needed to participants already served under the DD Waiver. Only two (2) new participants entered into DD Waiver services via this criterion during year five of the expiring waiver. This number is expected to remain constant. Therefore, the historic number of participants entering into DD Waiver services annually via this priority category is expected to remain steady at two (2) participants per year for years one through five of the Renewal.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 2 |
| Year 2 | 2 |
| Year 3 | 2 |
| Year 4 (renewal only) | 2 |
| Year 5 (renewal only) | 2 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (•) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- (•) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity

and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

With the exception of individuals meeting reserved capacity (priority) criteria noted in Appendix B-3-c, entrance to the DD Waiver is governed on a first come, first served basis by the applicant's signed and dated application for waiver services.

The applicant or legal representative is asked to sign the STATEMENT FOR FREEDOM OF CHOICE form [State Form 46016 (R8/4-02)/HCBS 0003] described under Appendix B-7. If the QMRP Intake Service Coordinator (serving as an Intake Case Manager) determines that the individual does meet ICF/MR level of care, the individual will be assigned a waiver slot, if one is available. When no slot is available, the individual's name will be placed on the DD Waiver's single statewide waiting list. Thereafter, the selection (targeting) process toward filling available slots is managed on a first come, first served basis, using the date of application for DD Waiver services following the Bureau of Developmental Disabilities' Targeting Process for DD Eligible Individuals Under ICF/MR Level of Care Waivers.

Participants being served under any other 1915(c) home and community-based services waiver shall not be concurrently served under the DD Waiver.

As noted within the Application (Module 1), upon being targeted, acceptance of and established eligibility for a DD Waiver slot by the potential participant and/or his/her legal guardian will require the removal of that potential participant's name from all other Indiana Medicaid Home and Community Based Services waiver program waiting lists.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ○ **SSI Criteria State**
   - ◉ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- [x] **Low income families with children as provided in §1931 of the Act**
- [ ] **SSI recipients**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act
Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII)
Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII)
Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV)
Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI)
Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII)
Transitional Medical Assistance – Sec 1925 of the Act

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***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

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- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

- [x] **A special income level equal to:**

*Select one*:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

  Specify percentage:
- **A dollar amount which is lower than 300%.**

  Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  *Select one*:

  - **100% of FPL**
  - **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    *(Complete Item B-5-c (209b State) and Item B-5-d)*

- **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  *(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)*

- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  *(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- **The following standard included under the State plan**

  (*select one*):

  - **The following standard under 42 CFR §435.121**

    *Specify:*

  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify percentage:
    - **A dollar amount which is less than 300%.**

Specify dollar amount:

- **A percentage of the Federal poverty level**

  Specify percentage:

- **Other standard included under the State Plan**

  *Specify:*

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  *Specify:*

- **Other**

  *Specify:*

**ii. Allowance for the spouse only** (*select one*):

- **Not Applicable (see instructions)**
- **The following standard under 42 CFR §435.121**

  *Specify:*

- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  *Specify:*

  Subtract the SSI maximum Federal Benefit Rate (FBR) for an individual from the SSI maximum FBR for a couple.

**iii. Allowance for the family** (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**

- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  *Specify:*
- **Other**
  *Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 4)

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this**

**section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

**ii. Frequency of services.** The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

Identified needs of the participant served under the DD Waiver must be such that the participant requires the provision of at least one DD Waiver service on a quarterly basis (as evidenced by the service plan) in order to avoid institutionalization. All participants, including those for whom less than monthly service provision is required, shall require regular monthly monitoring which shall be documented in the service plan. Requirements for monitoring the participant at least monthly are specified in Appendix D-2-a of this application.

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- **Other**

*Specify:*

Initial Level of Care evaluations are performed by the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator employed by the operating agency specified in Appendix A, (the Division of Disability and Rehabilitative Services) , with the following exceptions: 1) the individual targeted for waiver services is age 5 or younger, or 2) the individual is currently a resident of an ICF/MR facility and has been cited by the Indiana State Department of Health with a W-197 or W-198 tag, indicating a violation of a federal standard.

•The W197 tag = active treatment does not include services to maintain generally independent participants who are able to function with little supervision or in the absence of a continuous active treatment program.
•The W198 tag = participants who are admitted by the facility must be in need of and receiving active treatment services

Under these exceptions, the level of care determination is made by the BDDS Level of Care Unit, also employed by the operating agency specified in Appendix A.

Reevaluations are performed by the contracting entity of case management services.

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Only state employees who are qualified as Qualified Mental Retardation Professionals (QMRP) as specified by the standard within 42 CFR 483.430(a) may perform initial Level of Care determinations.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To complete a level of care determination, the BDDS Intake Service Coordinator (for initial determinations) or contracted Intake and Assessment Specialist (case manager)(for reevaluations) must obtain and review the following:

1) Psychological records including I.Q. score;
2) Social assessment records;
3) Medical records;
4) Additional records necessary to have a current and valid reflection of the individual;
5) A completed Medicaid Form 450B medical form, signed and dated by a physician within the past year.

If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted Diagnosis and Evaluation (D&E) team. The D&E teams are contracted through the Bureau of Developmental Disabilities Services. The Teams include psychologists, physicians, nurses and licensed social workers.

In addition to reviewing the collateral records, the QMRP Intake Case Manager/Service Coordinator must perform a Developmental Disabilities Profile (DDP), applicable to individuals with mental retardation and other related conditions. Additional information regarding administration of the DDP and the DDP for Children is found in Appendix D-1-d.

The DDP assessment tool:
• collects and considers the vocational programs of applicant/participant
• identifies all developmental disabilities applicable to the applicant/participant as well as any psychiatric diagnosis and results of the individual's intellectual assessment
• reports status of hearing and vision
• identifies the alleged perpetration of crimes committed by the applicant/participant as well as the need for police involvement for maladaptive behaviors
• identifies barriers which hinder the achievement of personal independence, productivity, integration and community inclusion as well as barriers which hinder achieving the identified lifestyle and related needs
• identifies significant medical conditions requiring specialized medical supports or impacting the participation in services
• looks at the utilization and frequency of health-related services including the identification and detailing of issues within the respiratory, cardiovascular, gastro-intestinal and genito-urinary systems, and any evidence of neoplastic or neurological diseases
• identifies any seizures by type, frequency and required medications
• identifies medication support needs and medical consequences related to the above conditions
• addresses mobility issues, motor control, cognitive and communication abilities
• assesses the frequency and consequences of behaviors
• examines self care and activities of daily living support needs
• determines the need for and frequency of utilization of clinical services

When the DDP pertains to a child who is age 6 but not yet age 11, the DDP Children's Assessment is administered. As noted in Appendix B-6-b, exceptions regarding the bearer of responsibility for determining Level of Care for children under age 6 as well as for individuals who live in a facility and are cited with a W-197 or W-198 tag by the Indiana State Department of Health (ISDH) is deferred to the BDDS Level of Care Unit.

The Intake Service Coordinator or Case Manager reviews the DDP and collateral material, including the report of an independent assessment organization, if available. To meet level of care, an applicant/participant must receive a score of 28 or higher on the DDP and meet each of four basic qualifications and three of six substantial functional limitations.

The basic qualifications are: 1) mental retardation, cerebral palsy, epilepsy, autism, or condition similar to mental retardation, 2) the condition identified in #1 is expected to continue, 3) the condition identified in #1 had an age of onset prior to age 22, and 4) the applicant needs a combination or sequence of services.

The substantial functional limitation categories, as defined in 42 CFR 435.1009, are: 1) self-care, 2) learning, 3) self-direction, 4) capacity for independent living, 5) receptive and expressive language, and 6) mobility.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The DDP, fully described in Appendix B-6-d, is the required instrument to be used in determining waiver level of care. The DDP is used in addition to the collateral information that is required to be used for institutional level of care determination.

The Intake Service Coordinator (for initial evaluations) or contracted waiver Case Manager (for reevaluations) reviews the DDP and collateral material, including the report of an independent assessment organization, if available. To meet waiver level of care, an applicant/participant must receive a score of 28 or higher on the DDP and meet each of four basic qualifications and three of six substantial functional limitations.

The use of the DDP is not required in determining institutional level of care.

The DDRS has developed an enhanced review process for monitoring accuracy of LOC determinations made by Service Coordinators and Case Managers. The BDDS management team, consisting of the BDDS District Managers and Field Service Directors, monitors and takes actions to address inappropriate LOC decisions.

An ICF/MR LOC Review Committee has been established to collect data regarding LOC determinations and compile a written quarterly report including recommendations for quality improvement. Patterns of inappropriate decisions made by a Service Coordinator or Case Manager are to be identified and addressed. If the data shows a system issue resulting in inappropriate decisions, the issue is referred to the BDDS Case Management Liaison or BDDS Director of Client Services to identify, address and monitor the training provided to Service Coordinators and Case Managers.

The BDDS management team will conduct quality assurance audits of LOC determinations to review for accuracy and appropriateness of at least 3% of waiver participants annually. The 3% sample is determined randomly and includes both initial and annual LOC determinations for the Developmental Disabilities, Autism and Support Services waivers, but sampling results may also be tracked by individual waiver.

A revised internal procedure has been developed to ensure consistent and accurate LOC determination across all BDDS districts and within the contracting case management entity. The BDDS management team reviews documentation provided via the LOC assessment tool, the Developmental Disabilities Profile (DDP), and additional supporting documentation used to determine LOC. If the outcome of the review is different from the original LOC determination, the BDDS would re-administer the DDP prior to a referral to the ICF/MR LOC Review Committee.

In the event that the BDDS management team arrives at a different LOC determination than either the BDDS Service Coordinator or waiver case manager, documentation of both determinations is reviewed by the ICF/MR LOC Review Committee. The review committee includes members of the BDDS executive management staff, the BDDS Case Management Liaison and the BDDS Policy Coordinator.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating

waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The level of care initial evaluation process is described in Appendix B-6-d and is performed by a BDDS Intake Service Coordinator.

The process for reevaluation of level of care is the same as the initial evaluation, but it is performed by the contracting waiver case management entity as opposed to the BDDS Intake Service Coordinator.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

*Specify the other schedule:*

Level of care reevaluations are required for each participant at least every twelve months. Level of care reevaluations will also be completed when there is significant change in the participant's health or circumstances.

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

*Specify the qualifications:*

**i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The state's electronic case management data system (INsite) allows case managers to run reports which will provide timely notification of the need for Level of Care (LOC) redeterminations for each recipient. DDRS staff will also be alerted to LOC evaluations near expiration through the periodic reports generated by INsite and will follow-up with case managers to assure redeteminations are completed and the LOC date is changed in the system.

Additionally, the contracting case management entity utilizes their own internal data system to monitor and track the timeliness of LOC determinations by the case managers they employ.

Note that the state's electronic case management data system (INsite) is programmed so that it does not permit the state's approval of a service plan (described in Appendix D) for which the level of care determination or redetermination has not been made within the past 12 months.

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained by the operating agency's Bureau of Developmental Disabilities Services office within the electronic case management data system (INsite) and are retrievable indefinitely upon request.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

**i. Sub-Assurances:**

**a.** ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of participants who received a level of care evaluation. Denominator: The total number of participants who apply for waiver services and/or are targeted for waiver services from the waitlist or through priority criteria.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DART and INsite Data Base**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 3% of all applicants who apply for DD Waiver services in an identified month |
| ☑ **Other** Specify: BDDS Field Operations | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** | |

| | | |
|---|---|---|
| | Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Field Operations | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of active DD Waiver participants who received reevaluation of level of care. Denominator: The total number of active DD Waiver participants for who should have received a level of care redetermination.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**INsite database reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| | | |

| | | |
|---|---|---|
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: BDDS Waiver Unit | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: BDDS Waiver Unit | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**c.** ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of times the processes and instruments were used appropriately in an identified month. Denominator: The total number of level of care determinations in any identified month.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**INsite databse reports and DART database reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: BDDS Field Operations | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| | |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Field Operations | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
An ICF/MR LOC Review Committee has been established to collect data regarding LOC determinations and compile a written quarterly report with recommendations for quality improvement. A full description of this procedure appears under Appendix B-6-e.

On a monthly basis, the operating agency, the BDDS Waiver Unit within the Division of Disability and Rehabilitative Services (DDRS), will run a series of reports to monitor the total number of participants for whom an annual renewal Plan of Care/Cost Comparison Budget (CCB) was due in that month, the number of annual CCBs actually received for that month and the number of annual CCBs for which no renewal was submitted. When the annual CCB is not submitted on time, a default CCB is created to ensure the continuation of services for the participant until the annual CCB is submitted. The BDDS Waiver Unit within DDRS is responsible for the review and approval of all CCBs and works with the DDRS Case Management Liaison to ensure the Liaison's awareness of these findings. The Liaison assumes responsibility for relaying these findings to the contracting case management entity.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ICF/MR LOC Review Committee and BDDS Waiver Unit | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the initial application for services process referenced under the Application (Module 1), the Bureau of Developmental Disabilities Services (BDDS) Intake Service Coordinator, serving in the role of a Medicaid Waiver Case Manager, is responsible for informing the applicant and/or his or her legal representative, if applicable, of the feasible alternatives available under the waiver. This activity will occur when it is determined that the applicant is an individual who, but for the provision of such services, would likely require the Intermediate Care Facility for the Mentally Retarded or persons with related conditions (ICF/MR) level of care, the cost of which could be reimbursed under the approved Medicaid State plan.

The applicant or legal representative is asked to sign the STATEMENT FOR FREEDOM OF CHOICE form [State Form 46016 (R8/4-02)/HCBS 0003] described below.

Once an applicant is determined to meet state and federal eligibility criteria and has been targeted or found to meet priority criteria, the applicant is referred to the contracting case management entity.

Note: The Intake & Assessment Specialist employed by the contracting case management entity presents the participant or legal representative with a Choice List (pick list) during the initial Intake meeting toward the selection of a Case Manager. The contractor's District Supervisor or Transition Specialist follows up with the applicant or legal representative shortly thereafter to coordinate interviews. When the participant or legal representative chooses a Case Manager, a Choice Statement is signed, dated and electronically stored in the contractor's database as well as in the participant's file. If the participant or legal representative does not find a suitable Case Manager among the choices presented, the Transition Specialist provides interim case management services and additional interview opportunities until a Case Manager is chosen.

Following the selection of a Case Manager and through the development of the initial service plan (referenced within the Application (Module 1) and Appendix A, Item 3 of this application), the contracting Case Manager is responsible for informing the applicant or legal representative, if applicable, of the feasible alternatives available under the waiver. The participant verifies that this information has been presented to them by signing Section I of the Plan of Care/Cost Comparison Budget described below. At least annually, and any time a new service plan is required, the contracting Case Manager will review this freedom of choice with the participant.

The applicant or legal representative is asked to sign the STATEMENT FOR FREEDOM OF CHOICE form [State Form 46016 (R8/4-02)/HCBS 0003] described below.

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

DESCRIPTION OF THE FORMS USED TO DOCUMENT FREEDOM OF CHOICE:

•STATEMENT FOR FREEDOM OF CHOICE (State Form 46016-HCBS 0003): Section 1 is completed only by "targeted" HCBS waiver participants who choose institutional placement. This form is signed and dated by the potential participant, the participant's family/guardian, representative or advocate, and the Medicaid waiver services Case Manager. The Case Manager is responsible for explaining the services available to the participant or potential participant in an institutional setting as well as the feasible alternatives available under the Medicaid HCBS Waiver Program. The participant or potential participant is informed that in order to be eligible for the waiver program, the costs of those services may not exceed the costs of institutional care.

Section II should only be completed if a "targeted" HCBS Waiver participant is currently on a Risk-Based Managed Care program or if an HCBS Waiver participant wants to transfer to a Risk-Based Managed Care program (if eligible). In Indiana, the programs are mutually exclusive. Individuals who are eligible under 42 CFR 435.217 are only Medicaid eligible if they are receiving home and community-based waiver services. The Medicaid Waiver Case Manager is responsible for explaining this exclusivity and the array of services available under the HCBS Waiver program.

•Plan of Care/Cost Comparison Budget: is used for only those individuals who choose waiver services. Once an individual is "targeted" for a waiver slot, is Medicaid eligible, and has met Level of Care approval, a Plan of Care/Cost Comparison Budget (POC/CCB) will be developed. The Plan of Care/Cost Comparison Budget (POC/CCB) is used for waiver participants at the time of initial determinations, updates, and annual re-determinations. A statement regarding freedom of choice is contained in Section I of the form. The waiver participant/guardian signs and dates this section indicating his/her choice of waiver services or institutional services. The Medicaid Waiver Services Case Manager is responsible for explaining the array of services available in an institutional setting as well as the feasible alternatives available through the Medicaid HCBS Waiver program.

A DESCRIPTION OF THE AGENCY'S PROCEDURE(S) FOR INFORMING ELIGIBLE PARTICIPANTS (OR THEIR LEGAL REPRESENTATIVES) OF THE FEASIBLE ALTERNATIVES AVAILABLE UNDER THE WAIVER:

•It is the responsibility of the Medicaid Waiver Services Case Manager to inform the participant/guardian of the services available in an institutional setting and the array of services available to meet that participant's needs through the Medicaid HCBS Waiver program.

Not only is the participant presented with the pick list of all providers approved to deliver the services desired by the participant, he or she is also given the list of providers that have expressed interest in providing those services after reviewing the needs of the participant using the contractor’s Web based system.

The participant-selected case manager presents the participant with the printed pick list containing all providers approved by the State to offer the waiver service(s) desired and needed by the participant. The pick list is specific to those providers approved to offer services in the county or counties where service delivery is desired by the participant. Interested providers are contacted by the waiver Case Manager only after the participant has ample opportunity to review the responses and indicates a mutual interest in interviewing the provider.

In all cases, the participant reserves the right to contact any State-approved provider from whom they may desire to receive their services and with whom a mutual agreement to deliver services may potentially be reached.

A DESCRIPTION OF THE STATE'S PROCEDURES FOR ALLOWING INDIVIDUALS TO CHOOSE EITHER INSTITUTIONAL OR HOME AND COMMUNITY-BASED SERVICES:

•Eligible individuals are provided with a choice of either institutional or home and community-based services through the use of the STATEMEMT FOR FREEDOM OF CHOICE and the Plan of Care/Cost Comparison Budget forms. It is the responsibility of the Medicaid Waiver Services Case Manager to fully inform the participant/guardian of the services available in an institutional setting and the array of services available to meet the needs of the participant or potential participant through the Medicaid HCBS Waiver. After becoming familiar with the alternatives, the participant/guardian is provided the opportunity to decide which option best serves his/her needs. Language contained in both the STATEMENT FOR FREEDOM OF CHOICE and the Plan of Care/Cost Comparison Budget forms verifies that the participant or potential participant has been fully informed of the services

available in the institutional setting and the feasible alternatives under the HCBS Waiver, and that the participant/guardian has made an informed, voluntary choice. Individuals who choose to have their needs met through the Medicaid HCBS Waiver are asked to make an informed choice about the services they want to receive to meet their need, and from which approved provider they want to receive the services.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The initial signed and dated STATEMENT FOR FREEDOM OF CHOICE form is maintained within the Bureau of Developmental Disabilities Services Field Office having jurisdiction over the participant's county of residence.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
As an integral part of the operating agency, the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Deaf and Hard of Hearing Services serves as a resource for interpreter services to the deaf and hard of hearing. As needed, the operating agency is able to assist with referrals for sign language interpreters toward the effective communication with applicants or participants, when interpreter services are not already included on the service plan of the participant.

The operating agency relies heavily on the English proficient family members or friends of the applicant/participant to interpret in the native language of the applicant/participant. Staff members of the operating agency sometimes utilize locally available interpreters associated with community or neighborhood organizations and church groups for interpretation of non-English languages. Some metropolitan communities within Indiana offer access to interpreters of varying languages through local colleges, universities or libraries.

The http://www.imcpl.org/cgi-bin/irnget.pl?Interpreters is a website offering connections to Asian, Latino, and American Sign Language interpreters within the Marion County/Indianapolis area as well as the translation of personal documents.

As outlined within the Individualized Support Plan (ISP) and incorporated in the Plan of Care/Cost Comparison Budget (CCB), providers of services are expected to meet the needs of the participants they serve, inclusive of effectively and efficiently communicating with each participant by whatever means is preferred by the participant. If the participant is a Limited English Proficient (LEP) person, the provider is expected to accommodate those needs during the delivery of any and all services they were chosen to provide.

Recognizing the need to improve access to and availability of interpreters of non-English languages, especially for those less commonly spoken, the operating agency will explore the use of reliable web-based interpreter services which may be employed to translate applications, service plans, freedom of choice statements, Notices of Action, pick lists and other written materials into non-English languages when a significant number or percentage of program participants require information in a particular language other than English.

Assisting the operating agency toward that end, the contracting entity of case management services, is able to provide limited bilingual services by employing Case Managers who are bilingual. Specifically, the contractor employs Case Managers around the State who are fluent in Spanish as well as American Sign Language.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service |
|---|---|
| **Statutory Service** | **Adult Day Services** |
| **Statutory Service** | **Prevocational Services** |

| | |
|---|---|
| **Statutory Service** | **Rent and Food for Unrelated Live-in Caregiver** |
| **Statutory Service** | **Residential Habilitation and Support** |
| **Statutory Service** | **Respite** |
| **Statutory Service** | **Supported Employment Follow Along** |
| **Extended State Plan Service** | **Occupational Therapy** |
| **Extended State Plan Service** | **Physical Therapy** |
| **Extended State Plan Service** | **Psychological Therapy** |
| **Extended State Plan Service** | **Speech /Language Therapy** |
| **Other Service** | **Adult Foster Care** |
| **Other Service** | **Behavioral Support Services** |
| **Other Service** | **Community Based Habilitation - Group** |
| **Other Service** | **Community Based Habilitation - Individual** |
| **Other Service** | **Community Transition** |
| **Other Service** | **Electronic Monitoring** |
| **Other Service** | **Environmental Modifications** |
| **Other Service** | **Facility Based Habilitation - Group** |
| **Other Service** | **Facility Based Habilitation - Individual** |
| **Other Service** | **Facility Based Support Services** |
| **Other Service** | **Family and Caregiver Training** |
| **Other Service** | **Intensive Behavior Intervention** |
| **Other Service** | **Music Therapy** |
| **Other Service** | **Personal Emergency Response System** |
| **Other Service** | **Recreational Therapy** |
| **Other Service** | **Specialized Medical Equipment and Supplies** |
| **Other Service** | **Transportation** |
| **Other Service** | **Workplace Assistance** |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

Adult Day Services

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or

nutritious snacks are required. The meals need not constitute the full daily nutritional regimen. However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting in one of three available levels of service; Basic, Enhanced or Intensive.

Individuals attend Adult Day Services on a planned basis. A minimum of 3 hours to a maximum of 12 hours shall be allowable. The Three levels of Adult Day Services are Basic, Enhanced and Intensive.

A 1/2 day unit is defined as one unit of 3 hours to a maximum of 5 hours/day. Two units is more than 5 hours to a maximum of 8 hours/day. A maximum of two units/day is allowed.

A 1/4 day unit is defined as 15 minutes. Billable only after 8 hours of ADS have been provided on the same day. A maximum of of 16 units/day is allowed.

Allowable Activities

BASIC ADULT DAY SERVICES (Level 1) includes:
• Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed.
• Comprehensive, therapeutic activities.
• Health assessment and intermittent monitoring of health status.
• Monitor medication or medication administration.
• Appropriate structure and supervision for those with mild cognitive impairment.
• Minimum staff ratio: One staff for each eight individuals.

ENHANCED ADULT DAY SERVICES (Level 2) includes:
Level 1 service requirements must be met. Additional services include:
• Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
• Health assessment with regular monitoring or intervention with health status.
• Dispense or supervise the dispensing of medication to individuals.
• Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers.
• Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments.
• Minimum staff ratio: One staff for each six individuals.

INTENSIVE ADULT DAY SERVICES (Level 3) includes:
Level 1 and Level 2 service requirements must be met. Additional services include:
• Hands-on assistance or supervision with all ADLs and personal care.
• One or more direct health intervention(s) required.
• Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available.
• Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care.
• Therapeutic interventions for those with moderate to severe cognitive impairments.
• Minimum staff ratio: One staff for each four individuals.

Adult Day Services may be used in conjunction with Transportation Services.

Service Standards
• Adult Day Services must follow a written Plan of Care addressing specific needs determined by the individual's assessment.

Documentation Standards
• Services outlined in the POC/CCB.
• Evidence that level of service provided is required by the individual
• Attendance record documenting the date of service and the number of units of service delivered that day
• Completed Adult Day Service Level of Service Evaluation form

The case manager should give the completed Adult Day Service Level of Service Evaluation form to the provider.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Adult Day Services are allowed for a minimum of 3 hours to a maximum of 12 hours per day.

ACTIVITIES NOT ALLOWED
• Any activity that is not described in allowable activities is not included in this service.

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Adult Day Service Facilities |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Adult Day Services**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Adult Day Service Facilities
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-2 Qualification for ADS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and
Transportation Requirements.

Must comply with BDDS Adult Day Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For reapproval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Prevocational Services

**Alternate Service Title (if any):**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Prevocational Services are services that prepare a participant for paid or unpaid employment within one year of service implementation. The one year (12 month) clock begins with the start date of Prevocational Services as it appears on the approved Plan of Care/Cost Comparison Budget (CCB) and Notice of Action (NOA). Note that the 12 month clock does not begin with the date the service is first rendered or with the date the service is first billed for this time-limited service, unless those dates correspond to the start date of the service as it appears on the CCB and NOA.

Prevocational Services include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at generalized result. Services are habilitative in nature and not explicit employment objectives.

Group sizes: 8:1, 10:1, 12:1, 14:1 and 16:1

Allowable Activities:

Monitoring, training, education, demonstration, or support provided for up to 12 consecutive months from the start date of the service as it appears on the approved CCB and NOA, to assist with the acquisition and retention of skills in the following areas:

• Paid and unpaid training compensated less than 50% federal minimum wage

• Generalized and transferrable employment skills acquisition

Participants may also utilize Supported Employment Follow Along (SEFA) in conjunction with Pre-Vocational Services

Service Delivery Standards:

Pre-Vocational Services must be reflected in the ISP

All Pre-Vocational Services will be reflected in the participant's plan of care as directed to habilitative, rather than explicit employment objectives

Participant is not expected to be able to join the general workforce or participate in sheltered employment within one year (excluding Supported Employment)

Documentation Requirements:

• Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8)

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group services:

Upon request, the provider must be able to verify the following in a concise format:

• The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed:

Services that are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act

Services furnished to a participant in excess of 12 consecutive months from the start date of Prevocational Services as it appears on the approved CCB and NOA

Activities that do not foster the acquisition and retention of skills

Services in which compensation is greater than 50% federal minimum wage

Activities directed at teaching specific job skills

Sheltered employment, facility or community based

Services furnished to a minor by parent(s) or stepparents(s) or legal guardian

Services may not be furnished for a time period exceeding 12 consecutive months

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Prevocational Services Individual |
| Agency | DDRS Approved Prevocational Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Prevocational Services**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Prevocational Services Individual
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-20 Prevocational Services provider qualifications,
460 IAC 6-14-4 Staff Training
Must comply with BDDS Prevocational Services Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Prevocational Services**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Prevocational Agency
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-20 Prevocational Services provider qualifications,
460 IAC 6-14-4 Staff Training
Must comply with BDDS Prevocational Services Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Statutory Service

**Service:**
Live-in Caregiver (42 CFR §441.303(f)(8))

**Alternate Service Title (if any):**
Rent and Food for Unrelated Live-in Caregiver

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Rent and Food for an Unrelated, Live-in Caregiver Supports means the additional cost a participant incurs for the room and board of an unrelated, live-in caregiver (who has no legal responsibility to support the participant) as provided for in the participant's Residential Budget.

Allowable Activities:

• The individual participant receiving these services lives in his or her own home
• For payment to not be considered income for the participant receiving services, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver (who has no legal responsibilty to support the participant) must be made directly to the live-in caregiver
• Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
• Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
• Board: three meals a day or other full nutritional regimen
• Unrelated: unrelated by blood or marriage to any degree
• Caregiver: an individual providing a covered service as defined by BDDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the participant receiving services

Service Standards:
• Rent and Food for an Unrelated Live-in Caregiver should be reflected in the Individualized Support Plan of the individual
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
• Services must complement other services the participant receives and enhance increasing independence for the participant
• The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the participant and the type of support needed

Documentation Standards:

Rent and Food for Unrelated Live-in Caregiver documentation must include:

• Identified in the Individualized Support Plan
• Documentation of how amount of Rent and Food was determined
• Receipt that funds were paid to the live-in caregiver
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities not allowed:

• When the participant lives in the home of the caregiver or in a residence owned or leased by the provider of other services, including Medicaid waiver services
• When the live-in caregiver is related by blood or marriage (to any degree) to the participant and/or has any legal responsibility to support the participant

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Residential Habilitation and Support Provider |
| Agency | DDRS Approved Residential Habilitation and Support Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Rent and Food for Unrelated Live-in Caregiver**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Residential Habilitation and Support Provider
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-5-23 Rent/Food for Unrelated Live-In Caregiver Supports provider qualifications,
460 IAC 6-5-24 Qualifications for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Rent and Food for Unrelated Live-in Caregiver Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Rent and Food for Unrelated Live-in Caregiver**

**Provider Category:**
Agency

**Provider Type:**
DDRS Approved Residential Habilitation and Support Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
460 IAC 6-5-24 Qualifications for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Rent and Food for Unrelated Live-in Caregiver Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Residential Habilitation

**Alternate Service Title (if any):**

Residential Habilitation and Support

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Residential Habilitation and Support Services provide up to a full day (24-hour basis) of services and/or supports which are designed to ensure the health, safety and welfare of the participant, and assist in the acquisition, improvement, and retention of skills necessary to
support participants to live successfully in their own homes.

Billable either as:
• Intermittently, for 35 hours or less per week of RHS, OR
• Greater than 35 hours per week of RHS

Allowable activities:

RHS includes the following activities:

Direct supervision, monitoring and training to implement the
Individualized Support Plan (ISP) outcomes for the participant through the following:

• Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan)
• Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each participant's health record
• Assurance that direct service staff are aware and active individuals in the development and implementation of ISP and Behavior Support Plans
• May be used in conjunction with Transportation Services only when fewer than 35 hours per week of RHS are utilized

Service Standards:

• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan (ISP)
• Residential Habilitation and Support services should complement but not duplicate habilitation services being provided in other settings
• Services provided must be consistent with the participant's service planner

Documentation Standards:

RHS documentation must include:

• Services outlined in Individualized Support Plan
• Data record of consumer-to-staff service documenting the complete date and time entry (including a.m. or p.m.) All staff members who provide uninterrupted, continuous service in direct supervision or care of the participant must make one entry. If a staff member provides interrupted service (one hour in the morning and one hour in the

evening), an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the participant. The entry should include complete time and date of entry and at least the last name, first initial of the staff person making the entry

• If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse is required, the nurse's title should be documented.

• Any significant issues involving the participant requiring intervention by a Health Care Professional, Case Manager or BDDS staff member that involved the participant are also to be documented

• Quarterly reporting summaries are required

• RHS Invoicing Tool must be used in shared settings

• Documentation in compliance with 460 IAC 6

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed:

Reimbursement is not available through RHS in the following circumstances:

• Services furnished to a minor by the parent(s), step-parent(s), or legal guardian
• Services furnished to a participant by the participant's spouse
• Services to individuals in Adult Foster Care or Children's Foster Care
• Services that are available under the Medicaid State Plan
• Services furnished to an adult participant by a parent, step-parent or guardian, that exceed 40 hours per week per parent, step-parent, or guardian (no longer limited to a grand total of 40 hours per week)

Additionally:

• Providers may not bill for RHS reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with a participant, but this activity is not billable.)
• Providers may not bill for RHS reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS activity.)
• RHS and Electronic Monitoring services are not billable during the same time period.
• Intermittent use of RHS may not exceed thirty-five (35) hours of service per week
• RHS may not be used in conjunction with Transportation Services when 35 hours or more of RHS are utilized per week

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved RHS Agencies |
| Individual | DDRS Approved RHS Individuals |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Residential Habilitation and Support**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved RHS Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status,
460 IAC 6-5-24 Qualification for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider,
RN and LPN staff must meet IC 25-23, and
Transportation Requirements

Must comply with BDDS RHS Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Residential Habilitation and Support**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved RHS Individuals
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status,
460 IAC 6-5-24 Qualification for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,

460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider,
RN and LPN staff must meet IC 25-23, and
Transportation Requirements

Must comply with BDDS RHS Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Respite Care services means services provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite Care can be provided in the participant's home or place of residence, in the respite caregiver's home, in a camp setting, in a
DDRS approved day habilitation facility, or in a non-private residential setting (such as a respite home).

Activities Allowed:

• Assistance with toileting and feeding

• Assistance with daily living skills, including assistance with accessing the community and community activities

• Assistance with grooming and personal hygiene

• Meal preparation, serving and cleanup

• Administration of medications

• Supervision

• Individual services

• Group services (Unit rate divided by number of participants served)

Service Standards:

Respite care must be reflected in the Individualized Support Plan

Respite Nursing Care (RN) or Respite Nursing Care (LPN) services may only be delivered when skilled care is required

Documentation Standards:

SERVICE NOTES: A service note can include multiple discrete services as long as discrete services are clearly identified A service note must include:

1. Participant name

2. RID #

3. Date of Service

4. Provider rendering service

5. Primary location of services rendered

6. An activity summary for each block of time this service is rendered must exist and must include: duration, service, a brief description of activities, significant medical or behavioral incidents requiring intervention, or any other situation that is uncommon for the participant. A staff signature must be present for each block of time claimed on a service note. A new entry is not required unless a different discrete service is provided (i.e. one continuous note may exist even if the ratio changes)

For Group Services:

Upon request, the provider must be able to verify the following in a concise format:

• The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

Electronic signatures are acceptable if the provider has a log on file showing the staff member's electronic signature, actual signature and printed name
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed:

Reimbursement for room and board

Services provided to an participant living in a licensed facility-based setting

The cost of registration fees or the cost of recreational activities (for example, camp)

When the service of Adult Foster Care or Children's Foster Care is being furnished to the participant

Other family members (such as siblings of the participant) may not receive care or supervision from the provider while Respite care is being provided/billed for the waiver participant(s)

Respite care shall not be used as day/child care

Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the unpaid caregiver to go to work or to attend school

Respite care shall not be used to provide service to a participant while the participant is attending school

Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan

Respite care must not duplicate any other service being provided under the participant's Plan of Care/Individual Service Plan (POC/ISP)

Services furnished to a minor by a parent(s), step-parent(s), or legal guardian

Services furnished to a participant by the participant's spouse

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Licensed Home Health Agencies |
| Individual | DDRS Approved Respite Providers - Individual |
| Agency | DDRS Approved Respite Agencies |
| Individual | DDRS Approved Respite Providers - Individual - Skilled Nursing |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Licensed Home Health Agencies
**Provider Qualifications**
**License** *(specify):*
Home Health Agency IC 16-27-1, RN and LPN IC 25-23-1
**Certificate** *(specify):*
Home Health Aide Registered IC 16-27-1.5
**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with with BDDS Respite Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**

Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Respite Providers - Individual
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with with BDDS Respite Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Respite Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with with BDDS Respite Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Individual

**Provider Type:**
DDRS Approved Respite Providers - Individual - Skilled Nursing

**Provider Qualifications**

**License** *(specify):*
IC 25-23 Licensed and Registered Nurse

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with with BDDS Respite Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval BDDS and BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

Supported Employment Follow Along

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Supported Employment Follow Along services are services and supports (time-limited to 18 months per employment setting), that enable a participant who is paid at or above the federal minimum wage to maintain employment in a competitive community employment setting. The 18-month clock begins with the start date of the SEFA service as it appears on the approved Plan of Care/Cost Comparison Budget (CCB) and Notice of Action (NOA). Note that the 18- month clock does not begin with the date the service is first rendered or with the date the service is first billed for this time-limited service, unless those dates correspond to the start date of the service as it appears on the CCB and NOA.

In the following situations:

• Job in jeopardy – the participant will lose his/her job without additional intervention, or

• Career advancement – it is determined that the new job requires more complex, comprehensive, intensive supports than can be offered under the waiver, or

• Job loss,

the participant may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment Follow-Along and Vocational Rehabilitation Services will not be allowed

Allowable ratio: Individual, 1:1

Activities Allowed:

Reimbursement is available through Supported Employment Follow-Along Services for the following activities for up to 18 months per employment setting, based upon the service start date as it appears on the approved CCB and NOA:

• Time spent at the participant's work site: observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement

• At the request of the participant, off site monitoring may occur as long as the monitoring directly relates to maintaining a job

• Employment services occur in an integrated work setting

• The provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment

• Regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, and other appropriate professional and informed advisors, in order to reinforce and stabilize the job placement

• Facilitation of natural supports at the work site

• Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs

• Advocating for the participant , but

o only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment; OR

o with persons not directly affiliated with the employment site (i.e., parents, bus drivers, case managers, school personnel, landlords, etc.) if the person is hired and currently working

• Staff time used in traveling to and from a work site.

• Supports for up to 18 months per employment setting

Participants may utilize Workplace Assistance in conjunction with SEFA

Participants may also utilize Pre-Vocational Services in conjunction with SEFA

Service Standards:

When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting Services are tailored to the needs and interests identified in the person centered planning process and must be outlined in the Individualized Support Plan (ISP)

Documentation Standards:

Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Activities Not Allowed:

Reimbursement is not available under Supported Employment Follow Along services for more than 18 months per employment setting, with the 18-month clock starting with the service start date as it appears on the CCB and NOA. (A waiver participant who is unable to sustain competitive employment after 18 months of service/support

is considered inappropriately placed and continuing funding is not available without movement to a better-fit employment setting.)

Reimbursement is not available under Supported Employment Follow Along services for the following activities:

• Transportation of an individual participant

• Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142

• Activities taking place in a group, i.e., work crews or enclaves

• Public relations

• Community education

• In-service meetings, department meetings, individual staff development

• Incentive payments made to an employer to subsidize the employer's participation in a supported employment program

• Payments that are passed through to users of supported employment programs

• Sheltered work observation

• Payments for vocational training that is not directly related to an participant's supported employment program

• Any other activities that are non-participant specific, i.e., the job coach is working the job instead of the participant

• Any activities which are not directly related to the participant's vocational plan

• Services furnished to a minor by a parent(s), step-parent(s) or legal guardian

• Services furnished to a participant by the participant's spouse

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Supported Employment Follow Along - Individuals |
| Agency | DDRS Approved Supported Employment Follow Along Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Supported Employment Follow Along**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Supported Employment Follow Along - Individuals
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-29 Supported Employment provider qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Supported Employment Follow Along Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Supported Employment Follow Along**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Supported Employment Follow Along Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-29 Supported Employment provider qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Supported Employment Follow Along Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Extended State Plan Service

**Service Title:**
Occupational Therapy

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Occupational Therapy Services means services provided under 460 IAC 6-5-17 by a licensed/certified occupational therapist.

Allowable Activities
• Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function.
• Screening
• Assessments
• Planning and reporting
• Direct therapeutic intervention
• Design, fabrication, training and assistance with adaptive aids and devices
• Consultation or demonstration of techniques with other service providers and family members
• Participating on the interdisciplinary team, when appropriate, for the development of the plan

Service Standards
• Individual Occupational Therapy Services must be reflected in the Individualized Support Plan.
• The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards
• Documentation by appropriate assessment by a qualified therapist
• Services outlined in the Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACTIVITIES NOT ALLOWED
• Activities not delivered one-on-one with the individual
• Reimbursement for time spent in planning, reporting and write-up
• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

• Activities delivered in a nursing facility
• Activities that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Licensed/Certified Occupational Therapist |
| Agency | DDRS Approved Agency Providing Occupational Therapy |
| Agency | Home Health Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy**

**Provider Category:**
Individual
**Provider Type:**
Licensed/Certified Occupational Therapist
**Provider Qualifications**
**License** *(specify):*
IC 25-23.5 (Licensure and certification requirments)
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy qualifications

Must comply with BDDS Occupational Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Agency Providing Occupational Therapy
**Provider Qualifications**
**License** *(specify):*
Occupational Therapist IC 25-23.5
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy qualifications

Must comply with BDDS Occupational Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify):*
IC 16-27-1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy provider qualifications

Must comply with BDDS Occupational Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Physical Therapy

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Physical Therapy Services means services provided under this article by a licensed physical therapist

Allowed Activities
• Screening and assessment
• Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living
• Planning and reporting
• Direct therapeutic intervention
• Training and assistance with adaptive aids and devices
• Consultation or demonstration of techniques with other service providers and family members
• Participating on the interdisciplinary team, when appropriate, for the development of the service plan

Service Standards
• Individual Physical Therapy Services must be reflected in the Individualized Support Plan.
• The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards
• Physical Therapy Services documentation must include:
• Documentation by appropriate assessment
• Services outlined in the Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs, and chart detailing service provided, date, and times.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

ACTIVITIES NOT ALLOWED
• Activities not delivered one-on-one with the individual
• Reimbursement for time spent in planning, reporting and write-up
• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
• Activities delivered in a nursing facility
• Activities available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the waiver for this service)

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Licensed Physical Therapist |
| Agency | DDRS Approved Agency Providing Physical Therapy |
| Agency | Home Health Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Physical Therapy**

**Provider Category:**
Individual
**Provider Type:**
Licensed Physical Therapist
**Provider Qualifications**
**License** *(specify):*
IC 25-27-1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Qualifications

Must comply with BDDS Physical Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Physical Therapy**

**Provider Category:**
Agency

**Provider Type:**
DDRS Approved Agency Providing Physical Therapy
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Provider qualifications

Must comply with BDDS Physical Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-aproval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Physical Therapy**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify):*
IC 16-27-1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Provider qualifications

Must comply with BDDS Physical Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Psychological Therapy

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Psychological Therapy services means services provided under 460 IAC 6-3-56 by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

Allowable Activities
• Individual counseling
• Biofeedback
• Individual-centered therapy
• Cognitive behavioral therapy
• Psychiatric services
• Crisis counseling
• Family counseling
• Group counseling
• Substance abuse counseling and intervention

Service Standards
• Therapy Services should be reflected in the Individualized Support Plan of the individual.
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
• Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards
• Documentation by appropriate assessment
• Services outlined in the Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Activities Not Allowed:

• Reimbursement for time spent in planning, reporting and write-up

• Reimbursement is not available for Therapy Services when services are reimbursable through the Medicaid State Plan.

• Activities delivered in a nursing facility

• Activities that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).

• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's

school day

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Qualified Agencies |
| Individual | Licensed Psychologists |
| Individual | Clinical Social Worker |
| Individual | Marriage/Family Therapist |
| Individual | Mental Health Counselor |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Psychological Therapy**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Qualified Agencies
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with BDDS Psychological Therapy Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approvals, BDDS and BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Psychological Therapy**

**Provider Category:**
Individual
**Provider Type:**
Licensed Psychologists
**Provider Qualifications**
**License** *(specify):*
IC 25-33-1-5.1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with BDDS Psychological Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Psychological Therapy**

**Provider Category:**
Individual
**Provider Type:**
Clinical Social Worker
**Provider Qualifications**
**License** *(specify):*
IC 25-23.6
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with BDDS Psychological Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Psychological Therapy**

**Provider Category:**
Individual
**Provider Type:**
Marriage/Family Therapist
**Provider Qualifications**
**License** *(specify):*
IC 25-23.6
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with BDDS Psychological Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Psychological Therapy**

**Provider Category:**
Individual
**Provider Type:**
Mental Health Counselor
**Provider Qualifications**
**License** *(specify):*
IC 25-23.6
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with BDDS Psychological Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Extended State Plan Service
**Service Title:**
Speech /Language Therapy

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Speech-Language Therapy Services means services provided by a licensed speech pathologist under 460 IAC 6 Supported Living Services and Supports requirements.

Allowable Activities
• Screening
• Assessment
• Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
• Evaluation and training services to improve the ability to use verbal or non-verbal communication.
• Language stimulation and correction of defects in voice, articulation, rate and rhythm.
• Design, fabrication, training and assistance with adaptive aids and devices.
• Consultation demonstration of techniques with other service providers and family members.
• Participating on the interdisciplinary team, when appropriate, for the development of the plan.

Service Standards
• Individual Speech-Language Therapy Services must be reflected in the Individualized Support Plan.
• To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program.
• The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards
• Documentation of an appropriate assessment
• Services outlined in the Individualized Support Plan
• BDDS approved provider
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed

• Reimbursement for time spent in planning, reporting and write-up
• Activities not delivered one-on-one with the individual

• Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
• Activities delivered in a nursing facility

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Licensed Speech/Language Therapist |
| Agency | DDRS Approved Agency providing Speech/Language Therapy |
| Agency | Home Health Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Speech /Language Therapy**

**Provider Category:**
Individual
**Provider Type:**
Licensed Speech/Language Therapist
**Provider Qualifications**
**License** *(specify):*
IC 25-35.6
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech/Language Therapy Qualifications

Must comply with BDDS Speech/Language Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Speech /Language Therapy**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Agency providing Speech/Language Therapy
**Provider Qualifications**
**License** *(specify):*
IC 25-35.6 licensed Speech/Language Therapist
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech-Language Therapy provider qualifications

Must comply with BDDS Speech/Language Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Speech /Language Therapy**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify):*
IC 16-27-1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech-Language Therapy Provider Qualifications

Must comply with BDDS Speech/Language Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS and BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adult Foster Care

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Adult Foster Care Services means a living arrangement in which an participant lives in the private home of a principal caregiver who is unrelated to the participant.

Necessary support services are provided by the principal caregiver (a foster parent) as part of Adult Foster Care Services. Only agencies may be foster care providers, with the foster care settings being approved, supervised, trained, and paid by the approved agency provider. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Adult Foster Care Services, since these services are integral to and inherent in the provision of adult foster care services.

Rate Levels

There are three levels of rates. The Individualized Support Team (IST) determines what level of supports are required for the participant, based on what services an participant would utilize if foster care services were not available. A Service Planner must be completed showing the services and amounts of services required in another setting. If there are changes in the participant's condition that may call for a change in the level of service, the IST will re-determine what level of supports the participant requires, with ultimate approval given according to who can approve a specific level of service.

• Level 1 – Approved by Service Coordinator
• Level 2 – Approved by District Manager
• Level 3 – Approved by Central Office

Issues to consider in determining which tier of services the participant receives include the amount of time the foster family will need to spend in:

1) health and safety management;
2) challenges and experiences aimed at increasing a person's ability to live a lifestyle that is compatible with the person's interest and abilities;
3) modification or improvement of functional skills;
4) guidance and direction for social/emotional support; and
5) facilitation of both the physical and social integration of a person into typical family routines and rhythms.

Allowable Activities

• Personal care and services
• Homemaker or chore services
• Attendant care and companion care services
• Medication oversight
• Respite for the foster parent (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem)

• Other appropriate supports as described in the Individualized Support Plan

Service Standards
• Adult Foster Care Services must be reflected in the Individualized Support Plan
• Services must address the needs (for example, developmental needs, vocational needs, and so forth) identified in the person centered planning process and be outlined in the Individualized Support Plan
• 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the participant
• The provider determines the total amount per month paid to the foster parent
• The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
1) Publish written policies and procedures regarding foster parent support services;
2) Maintain financial and service records to document services provided to the individual;
3) Establish a criteria for the acceptance of the foster parent, screen potential foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check;
4) Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the foster parent;
5) Provide for the safety and well being of the participant by inspection of environment for compliance with DDRS policies and procedures, including, but not limited to, the provider and case management standards found in 460 IAC 6 Supported Living Services and Supports requirements; and
6) Reimburse foster parent.

Documentation Standards
• Adult Foster Care Services documentation must include the services outlined in the Individualized Support Plan.

Documentation by Providers:
• Written policies and procedures, including for screening and accepting foster parents.
• Maintain financial and service records to document services provided to the participant.
• Document provision of training to foster parents according to agency policies/procedures.
• Reimbursement of foster parent.
• One entry per participant per week (same as families).

Documentation by Families:
• One dated entry per day detailing an issue concerning the participant
• The entry should detail any outcome-oriented activities, tying those into measurable progress toward the participant's outcome (as identified in the ISP)
• The entry should also include any significant issues concerning the individual, including:
• Health and safety management
• Developmental challenges and experiences aimed at increasing an participant's ability to live a lifestyle that is compatible with the participant's interest and abilities
• Modification or improvement of functional skills
• Guidance and direction for social/emotional support
• Facilitation of both the physical and social integration of an participant into typical family routines and rhythms

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A participant in LEVEL 1 may reside with a family and up to three other participants (no more than four total), an participant in LEVEL 2 may not reside with more than one other participant. An participant in LEVEL 3 may not reside with any other participants in the AFC program.

ACTIVITIES NOT ALLOWED
• Services provided in the home of a caregiver who is related by blood or marriage, in any degree, to the participant
• The service of Residential Habilitation and Supports is not available to participants receiving the service of Adult Foster Care

**Service Delivery Method** *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved AFC Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Adult Foster Care**

**Provider Category:**
Agency

**Provider Type:**
DDRS Approved AFC Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-3 Adult Foster Care qualifications
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Adult Foster Care Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS and BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service

not specified in statute.
**Service Title:**
Behavioral Support Services

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Allowable Activities

Reimbursable activities of Behavioral Support Services include:
• Observation of the individual and environment for purposes of development of a plan and to determine baseline

• Development of a behavioral support plan and subsequent revisions
• Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
• Training in assertiveness
• Training in stress reduction techniques
• Training in the acquisition of socially accepted behaviors
• Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
• Consultation with team members

Service Standards
• Behavioral Support Services must be reflected in the Individualized Support Plan.

• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.

• The behavior supports specialist will observe the individual in his or her own milieu and develop a specific plan to address identified issues.

• The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active individuals in the development and implementation of the Behavioral Support Plan.

• The behavior plan will meet the requirements stated in 460 IAC 6-18-2.

• The behavior supports provider will comply with all specific standards in 460 IAC 6-18.

• Any behavior supports techniques that limit the individual's human or civil rights must be approved by the Individualized Support Team (IST) and the provider's human rights committee. No aversive techniques may be used. Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by the Individualized Support Team (IST) and the appropriate human rights committee.

• The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.

• The behavior specialist will provide a written report to pertinent parties at least quarterly. Pertinent parties includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities.

Documentation Standards

• Services outlined in the ISP.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACTIVITIES NOT ALLOWED
• Aversive techniques – Any techniques not approved by the individual's person centered planning team and the provider's human rights committee.

• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.

• Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.

• Services furnished to a participant by the participant's spouse.

• In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for Level 2 services only is allowed.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved BSS Agencies |
| Individual | DDRS Approved BSS Individuals |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Behavioral Support Services**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved BSS Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-4 Behavioral Support Services Provider qualifications
460 IAC 6-18 Behavior Support Services Standards

Must comply with BDDS Behavior Support Services Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**

Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Behavioral Support Services**

**Provider Category:**

Individual

**Provider Type:**

DDRS Approved BSS Individuals

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-4 Behavioral Support Services Provider Qualifications
460 IAC 6-18 Behavioral Support Services Standards

Must comply with BDDS Behavior Support Services Service Standards and Guidelines

BDDS approval requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**

Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Community Based Habilitation - Group

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Community Based Habilitation - Group are services provised outside of the Participant's home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community based activities are intended to build relationships and natural supports.

Allowable Ratios - 2:1, 3:1 and 4:1

Allowable Activities:

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

• Leisure activities and community/public events (i.e. integrated camp settings)

• Educational activities

• Hobbies

• Unpaid work experiences (i.e. volunteer opportunities)

• Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

• Develop self advocacy skills

• Exercise civil rights

• Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed

• Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards:

Community Based Habilitation Services must be reflected in the ISP.

Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Requirements:

• Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:
• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)

• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group services:
Upon request, the provider must be able to verify the following in a concise format:
• The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed:

Services that are available under the Rehabilitation Act of 1973 or PL 94-142.

Leisure activities that are not identified as individual habilitation outcomes.

Activities that do not foster the acquisition and retention of skills.

Services furnished to a minor by parent(s), step parents(s) or legal guardian.

Services furnished to a participant by the participant's spouse.

Services rendered in a facility.

Group size in excess of 4:1.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Community Based Habilitation Agencies |
| Individual | DDRS Approved Community Based Habilitation - Individuals |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Based Habilitation - Group**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Community Based Habilitation Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with BDDS Community Habilitation -Group Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Intially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Based Habilitation - Group**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Community Based Habilitation - Individuals
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with BDDS Community Habilitation -Group Service Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**

Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Community Based Habilitation - Individual

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Community Based Habilitation - Individual are services provised outside of the Participant's home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community based activities are intended to build relationships and natural supports.

Allowable Ratio - 1:1

Allowable Activities:

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

• Leisure activities and community/public events (i.e. integrated camp settings)

• Educational activities

• Hobbies

• Unpaid work experiences (i.e. volunteer opportunities)

• Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

• Develop self advocacy skills

• Exercise civil rights

• Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed

• Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards:

Community Based Habilitation Services must be reflected in the ISP.

Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Requirements:

• Services outlined in the Individualized Support Plan
• Need for service continuation and justification of goals is to be evaluated annually and reflected in the ISP

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:
• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed:

Services that are available under the Rehabilitation Act of 1973 or PL 94-142.

Leisure activities that are not identified as individual habilitation outcomes.

Activities that do not foster the acquisition and retention of skills.

Services furnished to a minor by parent(s), step parents(s) or legal guardian.

Services furnished to a participant by the participant's spouse.

Services rendered in a facility.

**Service Delivery Method** *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Agencies |
| Individual | DDRS Approved Individual |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Based Habilitation - Individual**

**Provider Category:**
Agency

**Provider Type:**
DDRS Approved Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications,and
Transportation Requirements

Must comply with BDDS Community Based Habilitation -Individual Service Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Based Habilitation - Individual**

**Provider Category:**
Individual

**Provider Type:**
DDRS Approved Individual
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with BDDS Community Based Habilitation -Individual Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Community Transition

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Community Transition Services include reasonable, one-time set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual and/ or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.

Items purchased through Community Transition Services are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition Services because those services are part of the per diem.

Allowable Activities
• Security deposits that are required to obtain a lease on an apartment or home.
• Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, bed or bath linens
• Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
• Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy
• When the individual is receiving residential habilitation and support services under the DD Waiver, the Community Transition Supports service is included in the Cost Comparison Budget

Service Standards
• Community Transition services must be reflected in the Cost Comparison Budget (CCB) of the individual.
• Services must address needs identified in the CCB.

Documentation Standards
• Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Community Transition Services are limited to one time set-up expenses, up to $1,000.

ACTIVITIES NOT ALLOWED
• Apartment or housing rental expenses
• Food
• Appliances
• Diversional or recreational items such as hobby supplies
• Television
• Cable TV access
• VCRs or DVD players

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Residential Habilitation and Support Provider |
| Agency | DDRS Approved Residential Habilitation and Support Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Transition**

**Provider Category:**
Individual

**Provider Type:**
DDRS Approved Residential Habilitation and Support Provider
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-34 Community Transitions Staff Qualifications
460 IAC 6-14-4 Staff Training

Must comply with BDDS Community Transition Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Transition**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Residential Habilitation and Support Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved Agencies
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-34 Community Transition Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Community Transition Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Electronic Monitoring

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Electronic Monitoring/Surveillance System & On-Site Response includes the provision of oversight and monitoring within the residential setting of adult waiver participants through off-site electronic surveillance. Also included is the provision of stand-by intervention staff prepared for prompt engagement with the participant(s) and/or
immediate deployment to the residential setting.

Activities Allowed:

• Electronic Monitoring/Surveillance System & On-Site Response may be installed in residential settings in which all residing adult participants, their guardians and their support teams request such surveillance and monitoring in place of on-site staffing.
• Use of the system may be restricted to certain hours through the Individualized Support Plans of the participants involved.

Service Standards:

To be reimbursed for operating an electronic monitoring and surveillance system, a provider must adhere to the following:
• The system to be installed must be reviewed and approved by Director of DDRS.
• The Electronic Monitoring/Surveillance System & On-Site Response system must be designed and implemented to ensure the health and welfare of the participant in his/her own home/apartment and achieve this outcome in a cost neutral manner.
• The case manager and/or the BDDS Service Coordinator will review the use of
the system at seven (7) days, and again at fourteen (14) days post installation.
• Services provided to waiver participants or otherwise reimbursed by the Medicaid program is subject to oversight/approval from the OMPP.

• Assessment and informed consent
o Initial assessment: Participants requesting this service must be preliminarily assessed by the Individualized Support Team (IST) for appropriateness in ensuring the health and welfare of the participants and have written approval by the human rights committee (HRC). These actions must be documented in the ISP and the DDRS case management system.
o Informed consent: Each participant, guardian and IST must be made aware of both the benefits and risks of the operating parameters and limitations. Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, case manager, and provider agency representative, as appropriate. A copy of the consent shall be maintained by the local BDDS office, the guardian (if applicable) and in the home file.
o Annual assessment updates: At least annually, the IST must assess and determine that continued usage of

the electronic monitoring system will ensure the health and welfare of the participant. The results of this assessment must be documented in the ISP and in the DDRS case management system. A review of all incident reports and other relevant documentation must be part of this assessment.

• System design

o The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the monitoring base and the participant's residential living site(s) in the event of electrical outages.

o The provider must have backup procedures for system failure (e.g., prolonged power outage), fire or weather emergency, participant medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant's ISP. This plan should specify the staff person or persons to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the participant's living site(s).

o The electronic monitoring system must receive notification of smoke/heat alarm activation at each participant's residential living site.

o The electronic monitoring system must have two way (at minimum,full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of participants in each living site, including emergency situations when the participant may not be able to use the telephone.

o The electronic monitoring system must allow the monitoring base staff to have visual (video) oversight of areas in participant's residential living sites deemed necessary by the IST.

o A monitoring base may not be located in a participant's residential living site.

o A secure (HIPAA compliant) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor or written information is limited to authorized staff including the parent/guardian, provider agency, Family and Social Services Administration (FSSA), DDRS, BDDS, Bureau of Quality Improvement Services (BQIS), Qualified Mental Retardation Professional, case manager, and participant.

o The equipment must include a visual indicator to the participant that the system is on and operating.

• Situations involving electronic monitoring of participants needing 24 hour support. If a participant indicates that he/she wants the electronic monitoring system to be turned off, the following protocol will be implemented:

a. The electronic caregiver will notify the provider to request an on-site staff.
b. The system would be left operating until the on-site staff arrives.
c. The electronic caregiver would turn off the system at that site once relieved by an on-site staff.
d. A visible light on the control box would signal when the system is on and when it is off.

• Monitoring base staff

o At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of participants at remote living sites.

o The monitoring base staff will assess any urgent situation at a participant's residential living site and call 911 emergency personnel first if that is deemed necessary, and then call the float staff person. The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the float staff or emergency personnel arrive.

o If computer vision or video is used, oversight of a participant's home must be done in real time by an awake-staff at a remote location (monitoring base) using telecommunications/broadband, the equivalent or better, connection.

o The monitoring base (remote station) shall maintain a file on each participant in each home monitored that includes a current photograph of each participant which must be updated if significant physical changes occur and at least, annually. The file shall also include pertinent information on each participant noting facts that would aid in ensuring the participants' safety.

o The monitoring base staff must have detailed and current written protocols for responding to needs of each participant at each remote living site, including contact information for staff to supply on-site support at the participant's residential living site when necessary.

• Stand-by intervention staff (float staff)

o The float staff shall respond and be at the participant's residential living site within 20 minutes or less from the time the incident is identified by the remote staff and float staff acknowledges receipt of the notification by the monitoring base staff. The IST Team has the authority to set a shorter response time based on individual participant need.

o The service must be provided by one (1) float staff for on-site response, the number of participants served

by the one (1) float staff is to be determined by the Individualized Support Team (IST) based upon the assessed needs of the participants being served in specifically identified locations.

o Float staff will assist the participant in the home as needed to ensure the urgent need/issue that generated a response has been resolved. Relief of float staff, if necessary, must be provided by the residential habilitation provider.

• Retention of written documentation is required for 7 years
• Retention of video/audio records, including computer vision, audio and sensor information, shall be retained for 7 years if an Incident Report is filed.

Documentation Standards:

To be reimbursed, the provider must prepare and be able to produce the following:
• Provider documentation
o Status as a DDRS/BDDS approved provider
o Approval of the specific electronic monitoring/surveillance system by the Director of DDRS.
o Case notes regarding the assessment and approval by both the IST of each participant and the HRC will be documented within both the DDRS system and the ISP.
o Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, case manager, and provider agency representative, as appropriate. Copies of consent documents will be maintained by the local BDDS office, the case manager, the guardian (if applicable) and in the home file.
o Utilization of the electronic monitoring device must be outlined in the ISPs, service planners and budgets of EACH participant in a setting, including typical hours of electronic monitoring

Each remote site will have a written policy and procedure approved by DDRS (and available to OMPP for all providers serving waiver participants) that defines emergency situations and details how remote and float staff will respond to each. Examples include:
o Fire, medical crises, stranger in the home, violence between participants, and any other situation that appears to threaten the health or welfare of the participant.
o Emergency Response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the electronic monitoring service. Documentation of the drills must be available for review upon request.

• The remote monitoring base staff shall generate a written report on each participant served in each participant's residential living site on a daily basis. This report will follow documentation standards of the Residential Habilitation Services. This report must be transmitted to the primary RHS provider daily.
• Each time an emergency response is generated, an incident report must be submitted to the State per the BDDS and BQIS procedures.
• At least every 90 days, the appropriateness of continued use of the monitoring system must be reviewed by the IST; the results of these reviews must be documented in the DDRS case management system and/or the ISP. Areas to be reviewed include but are not limited to the number and nature of responses to the home as well as damage to the equipment.

REIMBURSEMENT PARAMETERS:
The budget will be completed for each participant based upon the number of participants residing within the residence.

| | | |
|---|---|---|
| Tier 1 | 1 Participant in a home | $13.62 |
| Tier 2 | 2 Participants in a home | $ 6.81 |
| Tier 3 | 3 Participants in a home | $4.54 |
| Tier 4 | 4 Participants in a home | $3.41 |

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACTIVITIES NOT ALLOWED:

• Electronic monitoring and surveillance systems which have not received specific approval by the Director of the Division of Disability and Rehabilitative Services (DDRS).
• Electronic Monitoring may not be used concurrently with Adult Foster Care services or in the Adult Foster Care home
• Electronic Monitoring systems intended to monitor direct care staff
• Electronic Monitoring serves as a replacement for Residential Habilitation and Support (RHS) services, therefore, Electronic Monitoring and RHS services are not billable during the same time period
• Electronic Monitoring systems in ICF/MR facilities licensed under IC 16-28 and 410 IAC 16.2
• Electronic Monitoring systems used in place of in-home staff to monitor minors, i.e., participants under the age

of 18.
• Installation costs related to video and/or audio equipment
• Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
• Services furnished to a participant by the participant's spouse

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Electronic Monitoring Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Electronic Monitoring**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Electronic Monitoring Agency
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
To be approved to provide Electronic Monitoring/Surveillance System & On-Site Response services, a provider shall:
• Be an entity approved by DDRS/BDDS to provide Residential Habilitation and Support services
• Assure that the system must be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in his or her Individualized Support Plan (ISP)
• Assure that the stand-by intervention (float) staff meet the qualifications for direct support professionals as set out in 460 IAC 6-14-5.

DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training,
Must comply with BDDS Electronic Monitoring Service Standards and Guidelines.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Environmental Modifications

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
ENVIRONMENTAL MODIFICATIONS
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.
Waiver Services must approve all environmental modifications prior to service being rendered.

Allowable Activities
• Installation of ramps and grab bars
• Widening doorways
• Modifying existing bathroom facilities
• Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual
• Maintenance and repair of the items and modifications installed during the initial request
• Anti-scald devices

Service Standards
• Equipment and supplies must be for the direct medical or remedial benefit of the individual
• All items shall meet applicable standards of manufacture, design and installation to ensure that environmental modifications meet the needs of the individual and abide by established, federal, state, local and FSSA standards, as well as ADA requirements, approved environmental modifications will reimburse for necessary:
• Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications
• Independent inspections during the modification process and at completion of the modifications, prior to authorization for reimbursement, based on the complexities of the requested modifications.
• Equipment and supplies shall be reflected in the Individualized Support Plan
• Equipment and supplies must address needs identified in the person centered planning process

Documentation Standards
• Identified direct medical benefit for the individual
• Documented "Prior Authorization Denial" from Medicaid, if applicable
• Receipts for purchases
• Identified need in Individualized Support Plan
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000.

Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications that were funded by a waiver service.

(If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.)

ACTIVITIES NOT ALLOWED
• Adaptations to the home which are of general utility
• Adaptations which are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, central air conditioning)
• Adaptations which add to the total square footage of the home
• Adaptations that are not included in the comprehensive plan of care
• Adaptations that have not been approved on a Request for Approval to Authorize Services
• Adaptations to service provider owned housing. Home accessibility modifications as a service under the waiver may not be furnished to individuals who receive residential habilitation and support services except when such services are furnished in the participant's own home. Compensation for the costs of life safety code modifications and other accessibility modifications may not be made with participant waiver funds to housing owned by providers.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual |
| Agency | DDRS Approved Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Modifications**

**Provider Category:**
Individual
**Provider Type:**
Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual
**Provider Qualifications**
**License** *(specify):*
Home Inspector IC 25-20.2
Plumber IC 25-28.5
Physical Therapist IC 25-27-1
Occupational Therapist IC 25-23.5
Speech/Language Therapist IC 25-35.6

**Certificate** *(specify):*
Architect IC 25-4-1
**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-11 Environmental Modification Qualifications

Must comply with BDDS Environmental Modifications Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS and BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Modifications**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Agencies
**Provider Qualifications**

**License** *(specify):*
Home Health Agencies IC 16-27-1
Service provided by Licensed OT (IC 25-23.5) ,PT (IC 25-27-1),ST (IC 25-35.6)
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-11 Environmental Modification Qualifications

Must comply with BDDS Environmental Modifications Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approvals, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Facility Based Habilitation - Group

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Facility Based Habilitation services are services provided outside of the Participant's home in an approved facility that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

Allowable Ratios: 2:1, 4:1, 6:1 and 8:1

Allowable Activities:

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

Leisure activities (i.e. segregated camp settings)

Educational activities

Hobbies

Unpaid work experiences (i.e. volunteer opportunities)

Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

Develop self advocacy skills

Exercise civil rights

Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed

Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards:

Facility Based Habilitation Services must be reflected in the ISP.

Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards:

• Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity. *The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group services:

Upon request, the provider must be able to verify the following in a concise format:

• The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities Not Allowed

Services that are available under the Rehabilitation Act of 1973 or PL 94-142.

Leisure activities that are not identified as individual habilitation outcomes.

Activities that do not foster the acquisition and retention of skills.

Activities that would normally be a component of a person's residential life or services, such as: shopping, banking, household errands, medical appointments, etc.

Services furnished to a minor by parent(s) or step parents(s) or legal guardian.

Services furnished to a participant by the participant's spouse.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Facility Based Habilitation - Individuals |
| Agency | DDRS Approved Facility Based Habilitation Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Facility Based Habilitation - Group**

**Provider Category:**
Individual

**Provider Type:**
DDRS Approved Facility Based Habilitation - Individuals

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with BDDS Facility Based Habilitation -Group Service Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Facility Based Habilitation - Group**

**Provider Category:**
Agency

**Provider Type:**
DDRS Approved Facility Based Habilitation Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,

460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with BDDS Facility Based Habilitation -Group Service Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Facility Based Habilitation - Individual

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Facility Based Habilitiation - Individual are services provided outside of the participant's home in an approved facility that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

Allowable Ratio - 1:1

Allowable Activities:

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:
• Leisure activities (i.e. segregated camp settings)
• Educational activities
• Hobbies
• Unpaid work experiences (i.e. volunteer opportunities)
• Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

• Develop self advocacy skills
• Exercise civil rights
• Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed

• Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Delivery Standards:

Facility Based Habilitation - Individual services must be reflected in the ISP

Services must address needs identified in the person centered planning process and be outlined in the ISP

Documentation Requirements:

• Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity. *The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Activities Not Allowed:

Services that are available under the Rehabilitation Act of 1973 or PL 94-142

Leisure activities that are not identified as individual habilitation outcomes

Activities that do not foster the acquisition and retention of skills

Services furnished to a minor by parent(s) or step parents(s), or legal guardian

Services furnished to a participant by the participant's spouse

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|

| | |
|---|---|
| **Individual** | **DDRS Approved Facility Based Habilitiation individuals** |
| **Agency** | **DDRS Approved Facility Based Habilitation Agencies** |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Facility Based Habilitation - Individual**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Facility Based Habilitiation individuals
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
Transportation Requirements and
460 IAC 6-5-14 Health Care Coordination Services provider qualifications.

Must comply with BDDS Facility Based Habilitation -Individual Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Facility Based Habilitation - Individual**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Facility Based Habilitation Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with BDDS Facility Based Habilitation -Individual Service Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Facility Based Support Services

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Facility Based Support services are facility-based group programs designed to meet the needs of participants with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, therapeutic activities, supervision, support services, personal care and may also include optional or non-work related educational and life skill opportunities. Participants attend on a planned basis.
These services must be provided in a congregate, protective setting in groups not to exceed 16:1.

Activities Allowed:
• Monitor and/or supervise activities of daily living (ADLs) defined as dressing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
• Appropriate structure, supervision and intervention
• Minimum staff ratio: 1 staff for each 16 participants
• Medication administration
• optional or non-work related educational and life skill opportunities (such as how to use computers/computer programs/Internet, set an alarm clock, write a check, fill out a bank deposit slip, plant and care for vegetable/flower garden, etc. may be offered and pursued

Service Standards:

* Facility Based Support services must be reflected in the Individualized Support Plan

* Facility Based Support services must follow a written Plan of Care addressing specific needs as identified in the Individualized Support Plan

Documentation Standards:

• Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:
• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity. *The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.
For Group services

Upon request, the provider must be able to verify the following in a concise format:

• The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities not allowed:

• Any activity that is not described in allowable activities is not included in this service
• Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
• Services furnished to a participant by the participant's spouse
• Prevocational Services

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Facility Based Support Services Agencies |
| Individual | DDRS Approved Facility Based Support Services - Individuals |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Facility Based Support Services**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Facility Based Support Services Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-14 Health Care Coordination Services provider,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
Transportation Requirements and

Must comply with BDDS Facility Based Support Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS and BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Facility Based Support Services**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Facility Based Support Services - Individuals
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-14 Health Care Coordination Services provider,
460 IAC 6-14-5 Direct Care Staff Qualifications,

460 IAC 6-14-4 Staff Training,
Transportation Requirements and

Must comply with BDDS Facility Support Services Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Family and Caregiver Training

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Family and Caregiver Training Services provides training and education to:
(1) instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and
(2) improve the ability of the parent, family member or primary caregiver to provide the care to or for the individual.

Allowable Activities
• Treatment regimens and use of equipment
• Stress management
• Parenting
• Family dynamics
• Community integration
• Behavioral intervention strategies
• Mental health
• Caring for medically fragile individuals

Service Standards
• Family and Caregiver Training Services must be included in the Individualized Support Plan
• The Individualized Support Plan shall be based on the person centered planning process with that individual.

Documentation Standards
• Services outlined in the Individualized Support Plan
• Receipt of payment for activity
• Proof of participation in activity if payment is made directly to individual/family.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Funds for this service are limited to no more than $2,000/year

ACTIVITIES NOT ALLOWED
• Training/instruction not pertinent to the caregiver's ability to give care to the individual
• Training provided to caregivers who receive reimbursement for training costs within their Medicaid or state line item reimbursement rates
• Meals, accommodations, etc., while attending the training

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Family and Caregiver Training Individuals |
| Agency | DDRS Approved Family and Caregiver Training Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family and Caregiver Training**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Family and Caregiver Training Individuals
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-13 and 6-23-1 Family and Caregiver Training Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Family and Caregiver Training Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approvals, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family and Caregiver Training**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Family and Caregiver Training Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-13 and 6-23-1 Family and Caregiver Training Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Family and Caregiver Training Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Intensive Behavior Intervention

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Intensive Behavioral Intervention (IBI) is a highly specialized, individualized program of instruction and behavioral intervention. IBI is based upon a functional, behavioral and/or skills assessment of an individual's

treatment needs. The primary goal of IBI is to reduce behavioral excesses, such as tantrums and acting out behaviors, and to increase or teach replacement behaviors that have social value for the individual and increase access to their community. Program goals are accomplished by the application of research based interventions.

Generally, IBI addresses manifestations that are amenable to change in response to specific, carefully programmed, constructive interactions with the environment.

IBI must include:
• a detailed functional/behavioral assessment;
• reinforcement; and
• specific and ongoing objective measurement of progress;
• Family training and involvement so that skills can be generalized and communication promoted;
• Emphasis on the acquisition, generalization and maintenance of new behaviors across other environments and other people;
• Training of caregivers, IBI direct care staff, and providers of other waiver services;
• Breaking down targeted skills into small, manageable and attainable steps for behavior change;
• Utilizing systematic instruction, comprehensible structure and high consistency in all areas of programming;
• Provision for one-on-one structured therapy;
• Treatment approach tailored to address the specific needs of the individual.

Skills training under IBI must include:
• measurable goals and objectives (specific targets may include appropriate social interaction, negative or problem behavior, communication skills, and/or language skills);
• Heavy emphasis on skills that are prerequisites to language (attention, cooperation, imitation).

Activities Allowed:

• Preparation of an IBI support plan in accordance with 460 IAC 6-5-32

• Application of a combination of the following empirically-based, multi-modal and multidisciplinary comprehensive treatment approaches:

o Intensive Teaching Trials (ITT), also called Discrete Trial Training, is a highly specific and structured teaching approach that uses empirically validated behavior change procedures. This type of learning is instructor driven, and may use error correction procedures or reinforcement to maintain motivation and attention to task. ITT consists of the following:
(a) Antecedent: a directive or request for the individual to perform an action;
(b) Behavior: a response from the individual, including anything from successful performance, non-compliance, or no response;
(c) Consequence: a reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction; and
(d) A pause to separate trials from each other (inter-trial interval).

o Natural Environment Training (NET) is learner directed training in which the learner engages in activities that are naturally motivating and reinforcing to him or her, rather than the more contrived reinforcement employed in ITT.
o Interventions that are supported by research in behavior analysis and which have been found to be effective in the treatment of individuals with developmental disabilities which may include but are not limited to:

• Precision teaching: A type of programmed instruction that focuses heavily on frequency as its main datum. It is a precise and systematic method of evaluating instructional tactics. The program emphasizes learner fluency and data analysis is regularly reviewed to determine fluency and learning.

• Direct instruction: A general term for the explicit teaching of a skill-set. The learner is usually provided with some element of frontal instruction of a concept or skill lesson followed by specific instruction on identified skills. Learner progress is regularly assessed and data analyzed.

• Pivotal response training: This training identifies certain behaviors that are “pivotal” (i.e., critical for learning other behaviors). The therapist focuses on these behaviors in order to change other behaviors that depend on them.

o Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
o Additional methods that occur and are empirically-based.

• Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

Service Standards:

• An appropriate range of hours per week is generally between 20-30 hours of direct service. It is recommended that Intensive Behavioral Intervention Services be delivered a minimum of 20 hours per week. When fewer than 20 hours per week will be delivered, justification must be submitted explaining why the IST feels a number fewer than the recommended minimum is acceptable;

• At least quarterly, the Individualized Support Team (IST) must meet to review the IBI, consider the need for change, develop a new plan, or set new goals;

• IBI Services must be reflected in the Individualized Support Plan;

• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan;

• Services must be detailed in the IBI support plan;

• Services are usually direct and one-to-one, with the exception of time spent in training the caregiver(s) and the family; ongoing data collection and analysis; goal and plan revisions;

• The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities;

• The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

Documentation Standards:

Services outlined in the ISP.

Documentation in compliance with 460 IAC 6.

The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Activities Not Allowed:

• Aversive techniques as referenced within 460 IAC 6
• Interventions that may reinforce negative behavior, such as "Gentle Teaching"
• Group activities
• Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
• Services furnished to a participant by the participant's spouse Services furnished to a participant by the participant's spouse

• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's

school day

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Intensive Behavior Intervention Agency |
| Individual | DDRS Approved Intensive Behavior Intervention - Individual |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Intensive Behavior Intervention**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Intensive Behavior Intervention Agency
**Provider Qualifications**
**License** *(specify):*
For IBI Director:

Psychologist licensed under IC 25-33, or
Psychiatrist Licensed under IC25-22.5
**Certificate** *(specify):*
For IBI Case Supervisor:

IBI Case Supervisor must be BCBA or BCABA certified
**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Must Comply with BDDS Intensive Behavior Intervention Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Intensive Behavior Intervention**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Intensive Behavior Intervention - Individual
**Provider Qualifications**
**License** *(specify):*
For IBI Director:

Psychologist licensed under IC 25-33, or
Psychiatrist Licensed under IC25-22.5
**Certificate** *(specify):*
For IBI Case Supervisor:

IBI Case Supervisor must be BCBA or BCABA certified.
**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Must Comply with BDDS Intensive Behavior Intervention Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Music Therapy

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Music Therapy Services means services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

Allowable Activities
• Therapy to improve
Self-image and body awareness
Fine and gross motor skills
Auditory perception
• Therapy to increase
Communication skills
Ability to use energy purposefully
Interaction with peers and others
Attending behavior
Independence and self-direction
• Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative, impulsive) behaviors.
• Therapy to enhance emotional expression and adjustment.
• Therapy to stimulate creativity and imagination. The music therapist may provide services directly or may demonstrate techniques to other service personnel or family members

Service Standards
• Music Therapy Services should be reflected in the Individualized Support Plan of the individual
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan. Services must complement other services the individual receives and enhance increasing health and safety for the individual

Documentation Standards
• Documentation of appropriate assessment by a qualified therapist
• Services outlined in Individualized Support Plan
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACTIVITIES NOT ALLOWED

• Reimbursement for time spent in planning, reporting and write-up
• When services are reimbursable through the Medicaid State Plan.
• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
• Specialized equipment needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies Supports"
• Activities delivered in a nursing facility

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Music Therapist |
| Agency | Agency that Employs DDRS Approved Music Therapist |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Music Therapy**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Music Therapist
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Certified Music Therapist By a Certification Board for Music Therapist, that is Accredited by a National Commission for Certifying Agencies
**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-15 Music Therapy Provider Qualifications

Must comply with BDDS Music Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Music Therapy**

**Provider Category:**
Agency
**Provider Type:**
Agency that Employs DDRS Approved Music Therapist
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Certified Music Therapist by a Certification Board for Music Therapist, that is Accredited by a National Commission for Certifying Agencies.
**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-15 Music Therapy Provider qualifications

Must comply with BDDS Music Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Personal Emergency Response System

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

Allowable Activities
• PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.
• Device Installation service
• Ongoing monthly maintenance of device

Service Standards
• Must be included in the individual's plan of care.

Documentation Standards
• Identified need in the POC/CCB
• Documentation of expense for installation
• Documentation of monthly rental fee

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACTIVITIES NOT ALLOWED
• Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety.

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Personal Emergency Response System Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Emergency Response System**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Personal Emergency Response System Agencies
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-18 Personal Emergency Response System Qualifications

Must comply with BDDS Personal Emergency Response System Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Recreational Therapy

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Recreational Therapy Services means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to:
(1) improve the individual's functioning and independence; and
(2) reduce or eliminate the effects of an individual's disability.

Allowed Activities
• Planning, organizing and directing, Adapted sports, Dramatics, Arts and crafts, Social activities, other recreation services designed to restore, remediate or rehabilitate

Service Standards
• Recreational Therapy Services should be reflected in the Individualized Support Plan of the individual
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
• Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards
• Documentation by appropriate assessment
• Services outlined in Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs, and/or chart detailing service provided, date, and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
ACTIVITIES NOT ALLOWED

• Reimbursement for time spent in planning, reporting and write-up

• Payment for the actual activities being planned, organized and directed, when the services are reimbursable through the Medicaid State Plan

• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

• Activities delivered in a nursing facility

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Recreational Therapist |
| Individual | DDRS Approved Agency That Employs Approved Recreational Therapists |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Recreational Therapy**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Recreational Therapist
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-22 Recreational Therapy Provider Qualifications

Must comply with BDDS Recreational Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Recreational Therapy**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Agency That Employs Approved Recreational Therapists
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-22 Recreational Therapy provider qualifications

Must comply with BDDS recreational Therapy Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Specialized Medical Equipment and Supplies

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live and without which the individual would require institutionalization.
Waiver Services must approve all specialized medical equipment and supplies prior to service being rendered.

Allowable Activities
• Items necessary for life support
• Adaptive equipment and supplies
• Ancillary supplies and equipment needed for the proper functioning of specialized medical equipment and supplies
• Durable medical equipment not available under Medicaid State Plan
• Non-durable medical equipment not available under Medicaid State Plan
• Vehicle Modifications
• Communications devices
• Interpreter services

Service Standards
• Equipment and supplies must be of direct medical or remedial benefit to the individual
• All items shall meet applicable standards of manufacture, design and installation
• Any individual item costing over $500 requires an evaluation by a qualified professional such as a physician, nurse, Occupational Therapist, Physical Therapist, Speech and Language Therapist or Rehabilitation Engineer
• Annual maintenance service is available and is limited to $500 per year. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need

Documentation Standards
• Identified need in POC/CCB.
• Identified direct medical benefit for the individual.
• Documentation of the request for IHCP prior approval (denied PA).
• Documentation of the reason of denial of IHCP prior authorization.
• Receipts for purchases.
• Signed and approved Request for Approval to Authorize Services (State Form 45750)

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Service and repair up to $500 per year is permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by a waiver service. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

A lifetime cap of $15,000.00 is available for vehicle modifications. In addition to the $15,000.00 lifetime cap, $500.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that has been provided through the HCBS waiver. If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

ACTIVITIES NOT ALLOWED
• Equipment and services that are available under the Medicaid State Plan
• Equipment and services that are not of direct medical or remedial benefit to the individual
• Equipment and services that are not included in the comprehensive plan of care
• Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA)
• Equipment and services that are not reflected in the Individualized Support Plan
• Equipment and services that do not address needs identified in the person centered planning process

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agencies |
| Agency | DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider , Electronics Vendors |
| Individual | Licensed Speech/Language Therapist |
| Individual | Licensed Physical Therapist |
| Individual | Licensed/Certified Occupational Therapist |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify):*
IC 16-27-1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved

460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Must comply with BDDS Specialized Medical Equipment and Supplies Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Agency

**Provider Type:**
DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider , Electronics Vendors

**Provider Qualifications**

**License** *(specify):*
IC 25-26-13-18 Pharmacy

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-27 Specialized Medical Equipment & Supplies Provider Qualifications

Must comply with BDDS Specialized Medical Equipment and Supplies Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Individual

**Provider Type:**
Licensed Speech/Language Therapist

**Provider Qualifications**

**License** *(specify):*
IC 25-35.6
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Finanical Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Must comply with BDDS Specialized Medical Equipment and Supplies Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Individual
**Provider Type:**
Licensed Physical Therapist
**Provider Qualifications**

**License** *(specify):*
IC 25-27-1
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Must comply with BDDS Specialized Medical Equipment and Supplies Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Itiitially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Individual
**Provider Type:**
Licensed/Certified Occupational Therapist
**Provider Qualifications**
**License** *(specify):*
IC 25-23.5 Licensure and Certification requirements
**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Must comply with BDDS Specialized Medical Equipment and Supplies Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initiall, BDDS. For re-approvals, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Transportation

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
For waiver participants receiving fewer than 35 hours per week of Residential Habilitation and Support (RHS) services, including participants without RHS services, Transportation Services enable waiver participants to gain access to non-medical community services and resources, maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the Individualized Support Plan and plan of care.

Allowable Activities:

Two one-way trips per day to or from a non-medical community service or resource as specified on the ISP and provided by an approved provider of Residential Habilitation and Support, Community Based Habilitation,

Facility Based Habilitation, Adult Day Services or Transportation Services.

* Bus passes or alternate methods of transportation may be utilized
* May be used in conjunction with other services, including Residential Habilitation and Support (when fewer than 35 hours per week of Residential Habilitation and Support are provided), Community Based Habilitation, Facility Based Habilitation and Adult Day Services

Service Standards:

Transportation service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Transportation services under the waiver shall be offered in accordance with the individual's support plan, and when unpaid transportation is not available.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Documentation Standards:

SERVICE NOTES: A service note can include multiple discrete services as long as discrete services are clearly identified. A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.

A service note must include:
1. Consumer name
2. RID #
3. Date of Service
4. Provider rendering service
5. Pick up point and destination
6. If contract transportation is utilized, contractor must provide log and invoice support that includes date(s) of transportation provided.
7. If bus passes or alternative methods of transportation are utilized, invoices and attendance logs must support days for which round trips are billed to the waiver.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Activities not allowed:

• May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan
• May not be used by participants receiving 35 or more hours per week of Residential Habilitation and Support Services

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | DDRS Approved Transportation Provider - Individual |
| Agency | DDRS Approved Transportation Provider - Agency |

## Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Individual
**Provider Type:**
DDRS Approved Transportation Provider - Individual
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS Transportation Service Standards and Guidelines
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Transportation Provider - Agency
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,

460 IAC 6-14-4 Staff Training

Must comply with BDDS Transportation Service Standards and Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**

Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Workplace Assistance

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Workplace Assistance Services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the participant) or cuing to prompt the participant to perform a personal care task. Workplace Assistance services may be provided on an episodic or on a continuous basis.

Workplace Assistance Services are services that are designed to ensure the health, safety and welfare of the participant, thereby assisting in the retention of paid employment for the participant who is paid at or above the federal minimum wage.

Allowed Ratio - Individual, 1:1

Activities Allowed:

Direct supervision, monitoring, training, education, demonstration or support to assist with:

• Personal care while on the job or at the job cite (may included assistance with meals, hygiene, toileting, transferring, maintaining continence, administration of medication, etc.)

May be used in conjunction with Supported Employment Follow-Along services

May be utilized with each hour the participant is engaged in paid competitive community employment

Service Standards:

- Workplace Assistance Services must be reflected in the Individualized Support Plan
- Services must address needs identified in the person centered planning process and must be outlined in the ISP
- Workplace Assistance Services should complement but not duplicate community habilitation services being

provided in other settings

- Workplace Assistance Services may only be delivered in the employment setting. There is no requirement for a physician's prescription or authorization. The need for Workplace Assistance Services is determined entirely by the Individualized Support Team

Documentation Standards:

• Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

• Name of participant served
• RID Number of the participant
• Name of provider
• Service rendered
• Time frame of service (include a.m. or p.m.)
• Date of service including the year
• Notation of the primary location of service delivery
• A brief activity summary of service rendered
• Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
• Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).

Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Reimbursement for Workplace Assistance Services is available only during the participant's hours of paid, competitive community employment

Activities Not Allowed:

Reimbursement is not available through Workplace Assistance Services under the following circumstances:
• When services are furnished to a minor child by the parent(s) or step-parent(s) or legal guardian
• When services are furnished to a participant by that participant's spouse
• Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
• During volunteer activities
• In a facility setting
• In conjunction with sheltered employment
• During activities other than paid competitive community employment
• Workplace Assistance should complement but not duplicate services being provided under Supported Employment Follow Along services
• Workplace Assistance is NOT to be used for observation or supervision of the participant for the purpose of teaching job tasks or to ascertain the success of the job placement
• Workplace Assistance is NOT to be used for off site monitoring when the monitoring directly relates to maintaining a job
• Workplace Assistance is NOT to be used for the provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment
• Workplace Assistance is NOT to be used for regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, or other appropriate professional or informed advisors, in order to reinforce and stabilize the job placement
• Workplace Assistance is NOT to be used for the facilitation of natural supports at the work site
• Workplace Assistance is NOT to be used for Individual program development, writing tasks analyses, monthly reviews, termination reviews or behavioral intervention programs

• Workplace Assistance is NOT to be used for advocating for the participant
• Workplace Assistance is NOT to be used for staff time in traveling to and from a work site.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DDRS Approved Workplace Assistance Agencies |
| Individual | DDRS Approved Workplace Assistance - Individual |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Workplace Assistance**

**Provider Category:**
Agency
**Provider Type:**
DDRS Approved Workplace Assistance Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
Transportation Requirements and

Must comply with BDDS Workplace Assistance Service Standards and Guidelines.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.
**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Workplace Assistance**

**Provider Category:**
Individual

**Provider Type:**
DDRS Approved Workplace Assistance - Individual

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
Transportation Requirements and

Must comply with BDDS Workplace Assistance Service Standards and Guidelines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Initially, BDDS. For re-approval, BDDS or BQIS.

**Frequency of Verification:**
Up to 3 years.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) All waiver providers who have direct contact with waiver participants (including every employee, officer, or agent involved in the management, administration or provision of services under the Developmental Disabilities Waiver)must have criminal history checks.

b) As described within Appendix C, documented proof of the limited criminal history investigation is required and must be obtained from the Indiana central repository by the prospective provider agency before submitting the prospective provider's application for approval to provide services to the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Developmental Disabilities Services (BDDS). The documented proof must be on file at the time of original provider approval for all current employees.

Criminal history documentation requirements for providers are specified under 460 IAC 6-10-5 "General Administrative Requirements for Providers". The scope of the limited criminal history check is within the state and shall verify that the employee, officer, or agent has not been convicted of the following under Indiana Code Title 35. Criminal Law and Procedure or Title 31. Family Law and Juvenile Law:
• A sex crime (IC 35-42-4)
• Exploitation of an endangered adult (IC 35-46-1-12)
• Failure to report battery, neglect, or exploitation of an endangered adult (IC 35-46-1-13) or abuse or neglect of a child (IC 31-33-22-1)
• Theft (IC 35-43-4), if the person's conviction for theft occurred less than ten (10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5)
• Murder (IC 35-42-1-1)
• Voluntary manslaughter (IC 35-42-1-3)
• Involuntary manslaughter (IC 35-42-1-4)
• Felony battery
• A felony offense relating to a controlled substance

The provider shall also obtain a criminal history check from each county in which an employee, officer or agent involved in the management, administration or provision of services has resided within the three (3) years before the criminal history check is requested from the county.

c) The BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of documented proof of the limited criminal history for each employee listed on the provider's organizational chart, the application shall not be approved.

BQIS's comprehensive survey tool directs surveyors to checks that providers complete a criminal history background check on new hires and that , per 460 IAC 6-15-2, the provider rechecks criminal history backgrounds every three years. BQIS does this on a sample basis – for every provider that the individual works with BQIS checks one staff person's record. For example, if an individual receives residential habilitation, day program services, and behavioral clinician services the surveyor will select one staff person's personnel record from each provider agency. BQIS has instructed surveyors to request the record for the staff person who works most closely with the individual. If the agency cannot provide documentation of conducting this background check they are requested to develop a corrective action plan. Providers are encouraged to develop and implement systemic corrective actions.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

**Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The Certified Nursing Assistant Abuse Registry is maintained by the Indiana State Department of Health and is available online at https://extranet.in.gov/webLookup/Search.aspx

b) Per 460 IAC 6-10-5(d), "Documentation of Criminal Histories", the state Bureau of Developmental Disabilities Services (BDDS) requires Certified Nursing Assistant Abuse Registry screenings for each direct care staff member employed by a provider of waiver services. Each provider or prospective provider is responsible for conducting the screening against the registry.

The Certified Nursing Assistant Abuse Registry documentation requirements for providers are specified under 460 IAC 6-10, "General Administrative Requirements for Providers".

c) The BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the report from the state nurse aid registry for each direct care staff employed by the provider, the application shall not be approved.

The Bureau of Quality Improvement Services (BQIS) includes the requirement of reviewing for documented proof of the report from the state nurse aid registry for each direct care staff employed by the provider within provider surveys to verify that this practice continues with new hires.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

**No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Division of Disability and Rehabilitative Services (DDRS) conducts 4 orientation sessions for all types of prospective providers throughout the year. Orientation sessions are announced via DDRS Bulletins which are posted on the DDRS website. After attending the orientation session, the prospective provider decides whether or not to submit an application within thirty (30) days of the date of orientation.

The application approval process is managed/performed by the DDRS Provider Relations unit. This unit reviews all applications within thirty (60) days of receipt. The prospective provider is then given the opportunity to respond to any questions or additional information requested. The staff is available, upon request, to discuss in person questions regarding the application. The Provider Relations unit works with the potential provider to ensure all required documentation is obtained.

Information regarding the provider approval/enrollment process, provider qualifications required for particular services and other helpful information is also available to prospective services providers on the internet at DDRS website and by accessing the Indiana Medicaid HCBS Waiver Provider Manual, the Bureau of Developmental Disabilities Services help line, known as the BDDS Helpline and the Indiana Medicaid HCBS Guide for Consumers

(courtesy of the Indiana Governor's Planning Council for People with Disabilities).

Once the provider has successfully completed the application and is approved. A final approval is required by Community Residential Facilities Council/CRFC. If a prospective provider is seeking approval for Residential Services or Behavioral Management, an oral presentation/interview will be required. If/when final approval is awarded by CRFC, DDRS notifies the provider and directs them to contact Indiana's Medicaid fiscal intermediary to enroll as a Medicaid provider. (Medicaid enrollment is required for all waiver service providers.) When the provider is enrolled, DDRS is notified and the provider is added to the active provider data base.

# Appendix C: Participant Services

## Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of prospective new providers who submit applications/proposals. Denominator: The total number of prospective providers who are approved to provide waiver services.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Applications/Proposals submitted by prospective service providers**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Numerator: The total number of DDRS approved DD Waiver providers with no outstanding corrective action issues for any BQIS review activity (I.E. Comprehensive Survey, financial review, transition review, requested corrective action for identified incident report or mortality review trend) Denominator: The total number of non-licensed/non-certified providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider Re-Approval Survey**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| | | |

| | | |
|---|---|---|
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Numerator: The total number of potential providers who provide background checks in the application/proposal process. Denominator: The total number of potential providers who become approved providers.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Applications/Proposals submitted by prospective service providers**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>BDDS - Provider Relations | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of non-licensed/non-certified providers with unresolved issues identified through BQIS monitoring activities. Denominator: The total number of non-licensed/non-certified providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**CST database, case management database, Surveys, Reviews, Complaints, Reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: BDDS Provider Relations | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|

| | |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of participants with providers who have the necessary systems and supplies to implement sampled participants' support plans.**
**Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled participants with safety supports.**
**Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled participants' support staffs who know how to prevent, detect, and report allegations of abuse, neglect, mistreatment and exploitation. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled participants with staff who immediately recognize and respond to medical emergencies. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**

If 'Other' is selected, specify:

**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled particpants with provders who respect sampled participants' concers and respond accordingly. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| |
|---|
| ☑ **Continuously and Ongoing** |
| ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
BDDS Provider Relations works with organizations that are developing the required policies and procedures necessary for becoming waiver providers. Providers are not approved to render services until all of their requested information is validated. Once providers are approved and providing services for participants BQIS reviews providers by selecting a random sample of individuals and then focusing in on the providers that work with those participants. When instances are identified of providers not meeting qualifications and/or not conducting training as specified in state waiver regulations, providers are required to develop a corrective action plan to address their identified deficits. BQIS reviews and approves corrective action plans and validates that providers are implementing these as stated. Noncompliant providers are referred to the BQIS and BDDS Directors for follow-up action which may include being referred to the sanctions committee.

All survey information will be included in the web-based automated system that the state is currently building to support the survey process. As an interim measure for collecting information BQIS has built and is using an Access database to track and maintain review findings. When the automated system is fully operational providers will be able to access the system to insert their corrective actions directly into the database.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>BDDS Provider Relations | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

There are DD Waiver services that fall in this category. Environmental Modifications has a total lifetime limit of $15,000 which applies across any and all Environmental Modifications funded by Indiana Medicaid Home and Community Based Services waiver programs administered under the State Medicaid Agency.

Similarly, Vehicle Modifications (a component of Specialize Medical Equipment and Supplies) has a lifetime limit of $20,000, applicable across all waiver programs in the state.

Family Care Giver Training is limited to $2000 annually.

Additional limits exist in that a participant may not utilize Residential Habilitation and Support services for the same time period as Electronic Monitoring is being utilized, nor may the participant utilized Residential Habilitation and Support in conjunction with Adult Foster Care services as these sets of services are mutually exclusive by definition.

Each limit is established based upon historical expenditure and consistent with the previous DD Waiver limits.

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

With the transition to the Objective Assessment System for Individual Supports (OASIS), a budget amount will be allocated to the participant based upon a combination of factors.

This budget allocation limit is being put into place for the DD waiver participant to ensure a uniform objective method of determining the amount of funding needed to meet each participant's needs. The amount is determined using assessment information collected that reflects the needs of the participant. This assessment information is collected from multiple sources in different formats. First the demographic information is collected, this being age, and living situation. Next a functional assessment is completed using the Inventory for Client and Agency Planning ( ICAP). Lastly additional information not captured within these first 2 steps is collected, this is information relating to Behaviors, Health needs, specific day programs, and any family support needs.

Adjustments to the limit would result from one of the following possibilities. A rate change, the participant has a change in their needs, or the funding methodology is modified.

There are two forms of exceptions which are titled Review.
The first form of review, OASIS Review Process, (ORR) is related to the funding amount that was determined by the assessment information. The second review process, Budget Modification Review ( BMR), allows the participant to request short term increases in funding beyond the total amount if specific conditions apply.
The ORR provides the participant the ability to request that the assessment information be reviewed or redone to ensure that the information used to determine the participant funding accurately reflects the participant's needs. There is no time limit on requesting this review and it does not prohibit the participant from filing an appeal once a Notice of Action is created. The BMR provides the participant the ability to request additional funding for a short amount of time to meet their needs that are outside the original funding amount.

After the assessments are completed and the information received by the State, the participants and their support teams are required to review the information and ensure that it accurately reflects them. Once this is completed the participant will be notified in writing and verbally through their case manager of the funding amount.

The budget amount is being determined within the State of Indiana using a computer model developed by a nationally recognized contractor.

There is no geographic factor at this lime.

The methodology has been defined and presented throughout the state on multiple ( 25) occasions during 2007 & 2008. These presentations detailed the information that would be used from the assessments, demographic and additional information. The presentations are available, as well as bulletins describing the methodology.

Additionally all the information that is used in a specific participant's budget is reviewed and approved by the participant and their support team prior to notification of the budget.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The State employs another type of limit.
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**
Plan of Care/Cost Comparison Budget (CCB)

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

For participants receiving services under the DD Waiver, Case Management is a Medicaid Administrative service and not a Medicaid Waiver service. Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's care plan. Case Management is required in conjunction with the provision of any home and community–based service and enables an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner.

See Appendix D-1-d for additional and detailed responsibilities of the Case Manager. Appendix D-1-d also outlines the opportunities of the participant to engage and/or direct the process to the extent they wish, explains how those whom the participant wishes to attend and participate in developing the service plan are provided adequate notice, that the planning process is timely, that needs are assessed and services meet the needs, and that appropriate responsibilities of each participant, provider and/or support team member are identified.

CASE MANAGEMENT MINIMUM QUALIFICATIONS state that all case managers providing services must comply with one or more of the qualifications set forth below:

1. Holding a bachelor's degree in one of the following specialties from an accredited college or university:

(a) Social work
(b) Psychology
(c) Sociology
(d) Counseling
(e) Gerontology
(f) Nursing
(g) Special education
(h) Rehabilitation
(i) or related degree if approved by DDRS/OMPP representative

2. Being a registered nurse with one (1) year experience in human services.

3. Holding a bachelor's degree in any field with a minimum of one (1) year full-time, direct experience working with persons with developmental disabilities.

4. Holding a master's degree in a related field may substitute for required experience.

ADDITIONAL QUALIFICATIONS specific to the duties of the case management functions performed by the contracting entity of case management services and specified within the Indiana Administrative Code are noted as follows:

•460 IAC 6-5-5 indicates that the case manager must meet the requirements for a qualified mental retardation professional in 42 CFR 483.430(a).

SERVICE STANDARDS
•460 IAC 6-5-36 indicates that for the Person Centered Planning Process (detailed under Appendix D-1-d), the case manager shall complete the requirements set out in 460 IAC 7-4-1(c) "Development of an Individualized Support Plan (ISP)"; and
•460 IAC 7-4-1(c) indicates that an ISP shall be developed by an individual's support team using a "person centered planning" process. The support team shall be led by a facilitator chosen by the individual.

The Individualized Support Team (IST) shall be led by a trained facilitator chosen by the individual to collect and complete the profile information of the person centered planning process and development of the ISP. Before functioning as a facilitator of the person centered planning process a facilitator shall:

(1) complete a training provided by a Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS) approved training entity or person;
(2) observe a facilitation; and
(3) participate in a person centered planning meeting.

☐ **Social Worker.**

*Specify qualifications:*

☐ **Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a)The Plan of Care/Cost Comparison Budget (CCB) is developed within the Person-Centered Plan/Individualized Support Plan (PCP/ISP) Annual meeting. The Participant and/or family or legal representative are present during this meeting. The Person-Centered Plan drives the Individualized Support Plan which ultimately drives the Plan of Care/Cost Comparison Budget. (The Person-Centered Plan identifies the preferences and non-preferences of the Participant, ultimately identifying what is important to the Participant to accomplish or move toward within a given year. The Individualized Support Plan outlines the Participant's identified Outcomes and Health & Safety needs. The CCB is developed based upon the Outcomes of the Participant and the Health and Safety Needs of the Participant.)

(b)As part of the planning process for the Initial and/or Annual Person-Centered Plan/Individualized Support Plan meeting, the Participant designates other persons who know and work with this Participant to participate in the

development of the person's PCP/ISP. The Case Manager is then responsible for inviting the selected participants to the meeting.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)The plan is developed by the Individualized Support Team (IST) identified by the participant. The participant is the driving entity in the entire process. The CCB is developed a minimum of six weeks prior to the initial start date of services or six weeks prior to the end date of the current annual service plan. The CCB is routinely developed to cover a time frame of 12 consecutive months.

(b)Developmental Disabilities Profile (DDP): (participants age 6 and older) This assessment is one of the determinates of the Level of Care (LOC) process. The Developmental Disabilities Profile is completed with the Participant and two other informants. This standardized assessment tool is one of the determinants of the Level of Care process, noting that all Level of Care evaluations are to be completed by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CRF 483.430(a).

The initial DDP is completed by Bureau of Developmental Disabilities Services (BDDS) Intake Service Coordinator while subsequent determinations are completed by the Intake and Assessment Specialist of the contracting entity of case management services once the participant begins receiving services under the DD waiver.

Each DDP is to be completed with the participant and two reliable informants.

The DDP must be completed within one year of the approval date of any Initial CCB and within 90 days of the start date of each Annual CCB.

The Case Manager must ensure that the DDP continues to present an accurate assessment of the participant with any updated CCB that must be submitted.

Developmental Disabilities Profile (DDP) (for participants under the age of six) A child may be determined eligible using age-appropriate psychological and developmental assessments. Changes in adaptive functioning can occur frequently in children, therefore eligibility may need to be reviewed again between the ages of six and eighteen if there is a significant change in adaptive functioning. If the child's IQ score has been consistently below 55 on two or more tests administrated between the ages of six and eighteen with associated deficits in adaptive functioning, there may be no need for additional testing at age eighteen. Children with IQ scores above 55 and variations in adaptive functioning may need additional evaluation at age eighteen.

Intake and Assessment Specialist Interview: Prior to the Annual meeting, the Intake and Assessment Specialist meets with the Participant and/or family members, legal representative, and the Case Manager to identify and/or confirm health and safety needs. (The Meeting Issues & Requirements section of the Individualized Support Plan and the high risk assessment are reviewed during this interview.) The results of this interview are reviewed with the entire team at the Annual meeting. This information is reviewed at least every 90 days or as changes are necessary.

Risk Assessment: Provider agencies complete a risk assessment for each Participant they serve. The risk issues (i.e. health, behavioral, physical management, and environmental management) identified through the assessment are then addressed through the agency and potentially through coordination with Participant chosen specialists addressing the various risk needs.

Person-Centered Plan: The Cost Comparison Budget is driven by the Person-Centered Plan. The Person-Centered Plan identifies the participant's real desires, dreams and needs. Areas investigated within the Person-Centered Plan include: living situation/residence, community/inclusion, employment/work first, self-determination/rights, learning/personal development, wealth/material attainment, interpersonal relations/socialization and emotional well being. This assessment is completed by the Participant and identified team. This assessment is facilitated by the Case Manager during the annual meeting.

Health and Safety Indicator:
This is an assessment by the contracting entity of case management services that helps identify "important for" health and safety needs of an individual.

(c)The Participant is informed of available DD Waiver services on an ongoing basis throughout the year. The Participant's Case Manager is knowledgeable in all services available on the DD Waiver through which the Participant is purchasing services. Services are determined within each Initial, Annual or other meeting based upon the Participants outcomes and health and safety needs identified in the Individualized Support Plan (ISP).

(d)The Plan of Care/Cost Comparison Budget (CCB) is developed based upon a series of activities within the Initial, Annual or subsequent meeting of the Individualized Support Team including the Person-Centered Plan and the Individualized Support Plan. This entire process is driven by the Participant and is designed to recognize the Participant's needs and desires within the facilitation of the Annual process and the subsequent development of the Person-Centered Plan, the Individualized Support Plan, and the Cost Comparison Budget.

Information gathered during the Person-Centered Plan process is presented in the annual documents that are gathered by the Annual Specialist prior to the annual meeting. This is accomplished through a collaboration meeting with the Case Manager, followed by a series of structured conversations, beginning with the participant/ guardian. Other individuals, as identified by the participant that know them well and can provide pertinent information about them, will also be contacted for information.

The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The Annual Specialist will compile the annual documents based on their conversations, reviewing these with the case manager, and the case manager will then facilitate the annual meeting. At the annual meeting the case manager will discuss the documents, leading the team through a discussion of the tasks needed to accomplish the documented initiatives. The case manager will also lead the team through a discussion of services and budget allocations. The case manager then finalizes the ISP and completes the new CCB.

(e)Coordination of Waiver Services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible to ensure that all identified services and supports are in place as identified in the Individualized Support Plan and the Cost Comparison Budget. The Case Manager is responsible to monitor and coordinate services on an ongoing basis and to prevent lags, must record a weekly case note for each participant served. A formal 90 day review is completed by the case manager. Each service on the DD Waiver has a documentation standard which includes providing a monthly or quarterly report identifying the level of support provided to the participant based upon the identified supports and services in the Individualized Support Plan and the Cost Comparison Budget.

(f)The ISP identifies the services needed by the participant to pursue their desired projections and to address their health and safety needs. Each outcome within the ISP has associated initiatives addressing potential barriers or maintenance needs in relation to the projections. The initiative identifies the support the participant needs to pursue their desired projection. The initiative also identifies the Responsible Party, including the name of the agency, the waiver service code, and the name of the position responsible for the initiative. The participant may be the Responsible Party for an initiative if they so determine. In addition, each initiative has a specific timeframe identified, including a minimum review timeframe for each initiative.

The Plan of Care/Cost Comparison Budget (CCB) identifies:

The name of the Waiver service, the name of the Participant-chosen provider of that service, the cost of the service per unit, the number of units of service and the start and end dates for each Waiver service identified on the CCB.

(g)The plan is updated a minimum of every 365 days. The participant can request a change to the CCB at any point; be it a new service provider, or a change in the type or amount of service. The Individualized Support Plan and the CCB are reviewed a minimum of every 90 days. If a change of the Individualized Support Plan and/or the CCB is determined necessary during that time, the participant and/or family or legal representative and Participant-determined team will meet to discuss the change. The actual updating of the CCB is completed by the Case Manager based upon the participant and the Participant-determined team.

The Participant can request a change of service, service provider, or service amount at anytime during the annual year.

In the event that an Annual CCB is not submitted in a timely manner, the most recently approved CCB is automatically converted to a new Annual CCB containing uniform rates for all services appearing on the prior CCB. The total cost/amount of services on the "auto-converted", or" default", CCB is determined by the cost of services and supports appearing on the most recently approved but expiring CCB. The auto-converted, or default CCB ensures that there is no loss of services.

Early each month, the Division of Disability and Rehabilitative Services' (DDRS) Case Management Liaison monitors a monthly "dry run" report identifying participants whose Annual CCB is due to expire and therefore subject to the creation of a potential default CCB. Later in the month, the actual CCB Default Report is generated. The Liaison discusses Plan of Care/Cost Comparison Budget timeliness and any other relevant issues with management of the contracting entity of case management services as a part of their monthly meeting. These findings are also shared with DDRS Executive Management and the State Medicaid Agency, the Office of Medicaid Policy and Planning.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed based upon the following processes:

Intake and Assessment Specialist Interview: Prior to the Annual meeting, the Intake and Assessment Specialist of the contracting case management entity meets with the Participant and/or family members, legal representative, and the Case Manager to identify and/or confirm health and welfare needs. (The Meeting Issues & Requirements section of the Individualized Support Plan and the high risk assessment are reviewed during this interview.) The results of this interview are reviewed with the entire team at the Annual meeting.

High Risk Assessment: Provider agencies complete a risk assessment document for each participant they serve. The risk issues (i.e. health, behavioral, physical management, and environmental management) identified through the assessment are then addressed through the agency and potentially through coordination with participant chosen specialists addressing the various high risk needs.

Person-Centered Plan: The Plan of Care/Cost Comparison Budget (CCB) is driven by the Person-Centered Plan. Case managers working for the contracted case management entity receive Person Centered Planning training. The Person Centered Planning curriculum used for training was reviewed and approved by DDRS prior to implementation and is evidence-based training. Each case manager must pass the test with 85% or greater accuracy before performing these duties.

The Person-Centered Plan identifies the preferences and non-preferences of the Participant. Non-negotiables are also facilitated within the preference and non-preference areas of the Person-Centered Plan. A non-negotiable relates to something that is essential to ensure the health and welfare needs of the Participant. Areas investigated within the Person-Centered Plan include:

-Advocacy / Self-Determination,

-Community Participation / Involvement,
-Employment,
-Financial / Money Management,
-Health, Wellness, & Safety,
-Home/Living,
-Learning/Education,
-Leisure/Recreation,
-Meaningful Day,
-Relationships, and
-Rights & Responsibility.

This assessment is completed by the participant identified team and is facilitated by the Intake and Assessment Specialist during the annual meeting.

Any risk issues identified are addressed through participant specific risk plans to proactively and reactively address the risk issue. The participants within the Annual meeting review the risk issues and ensure that the plans in place are effective and efficient with supporting the participant in regard to the identified risk and the participant's preferences. All risk plans are identified in the Individualized Support Plan which drives the CCB. The CCB addresses risk areas specifically in the Emergency Back-Up section of the Cost Comparison Budget.

Risk plans for a participant are monitored by the BDDS field offices. The contracting case management entity uses the HSI (Health and Safety Indicator) as the assessment tool anyone can complete on a participant when there is any change of status and at least annually and for all intakes.

The State provides risk management training to individual providers on an as needed basis through the DDRS's Outreach Services. At any time, a provider may request additional training by the State.

The Outreach Services proactively weaves information and discussion about managing constipation into all applicable trainings offered in addition to the topic-specific training of "Hydration/Constipation/GERD". Trainings are routinely scheduled to occur up two times per month per topic. However, participant-specific trainings are often arranged outside of the routine schedule on an as needed basis. Urgent training needs are addressed immediately upon identification. Other routinely offered trainings include, "Health Assurance", "Basic Nutrition", "Seizure Management", and "Dysphagia". Tools, tracking systems, and development of plans to manage constipation as a means of preventing bowel obstruction are included. Additionally, Outreach provides person-specific consultation to providers and families.

Through Outreach services, DDRS is providing Health Assurance Reviews for participants in service who have identified health issues. The management of health conditions, including those that could lead to bowel obstruction, are assessed. Teams are provided with recommendations to enhance interventions as needed.

Health Assurance training is available through Outreach Services and includes instruction on developing comprehensive health plans including desired outcomes, history of health issue, interventions, training, monitoring and evaluation of plans and identified persons responsible. Beyond the routine scheduling, Health Assurance training is also offered on an as needed, individual basis as well as at the request of the provider. All training sessions are conducted by a licensed, registered nurse. Selected sessions presented by the licensed, registered nurse and an occupational therapist have been video-taped to increase availability and accessibility for providers.

Staff members from Outreach Services are consultants to providers. Providers are not required to implement Outreach Services' recommendations, however, it is anticipated that the team will consider the recommendations and implement all or some of them. To help determine if the recommendations are pertinent and are being implemented, Outreach surveys 5% of closed referrals 3 months following closure. One of the things asked in the survey is which recommendations were implemented and the impact. This is not done as a monitoring or enforcement practice, but to offer feedback to Outreach so they are aware of whether or not they are making feasible recommendations.

When participants recieve waiver services in their own homes where staff might not be continuously available, the service plan must include a back-up plan to address contingencies such as emergencies, including the failure of a direct caregiver to appear when scheduled to provide necessary services. Back-up plans are specified within the CCB and may include arrangements such as telephone calls to family, friends, neighbors, police or 911 emergency responders, walking to the home of a neighbor, or the use of a Personal Emergency Response System when approved the individual's IST.

The contractor of case management services maintains a 24-hour per day emergency response system that does not

rely upon the area 911 system and provides assistance to all DD waiver participants.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Participant can request a change of any service provider at anytime while receiving DD Waiver services. The Case Manager will assist the Participant with obtaining information about any and all providers available for a given service.

An electronic database is maintained by the operating agency that contains information regarding all qualified waiver providers for each service on the DD Waiver. Case Managers are able to generate a list of all qualified providers for each service on the waiver for the participant's use. Case Managers can assist the participant with interviewing potential providers and obtaining references on potential providers, if desired by the participant.

Case Managers are not allowed to give their personal or professional opinion on any waiver service provider. The case manager is responsible for the coordination of the transition of a provider once determined by the participant.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The submitted Plan of Care/Cost Comparison Budget (CCB) is reviewed by the DDRS' Waiver Services Unit. The DDRS staff will contact the case manager if there are any questions about the service plan.

Otherwise, the Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Disability and Rehabilitative Services (DDRS) as defined in the MOU. As part of its routine operations, DDRS will review each service plan submitted to ensure that the plan addresses all pertinent issues identified through the assessment, including physical health issues.

The OMPP will review and approve the policies, processes and standards for developing and approving DD Waiver plans of care. In the instance of a complaint from a DDRS provider, participant, family, or guardian, the CCB submitted to DDRS is available for OMPP review. Based on the terms and conditions of this DD Waiver, the Medicaid agency may overrule the approval or disapproval of any specific CCB acted upon by the DDRS, serving in its capacity as the administrating agency for the Indiana Medicaid Home and Community Based Services waiver program.

In addition, the OMPP is re-procuring a contract for the completion of additional field reviews. Individual service plans are reviewed against documented services rendered and services that were billed. The contracted entity is expected to review a designated percentage of the participants receiving services from the surveyed provider. As noted under Appendix A, the details for these review functions fall under the SUR contract developed and managed by OMPP.

OMPP will oversee the contractor's waiver reviews through regularly scheduled meetings with the contractor and reports of the contractor's reviews. Additionally, OMPP staff may periodically accompany the contractor on-site to observe the reviews.

Further, for purposes of oversight and quality control, OMPP will annually complete a random sample of applications and plans of care. As part of this annual sample, OMPP may request additional documentation from DDRS, the participant, the family/guardian or providers as necessary.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

*Specify the other schedule:*

The plan is updated a minimum of every 365 days. The Individualized Support Plan and the Plan of Care/Cost Comparison Budget are reviewed formally a minimum of every 90 days. The participant can request a change to the Plan of Care/Cost Comparison Budget at any point; be it a new service provider, or a change in the type or amount of service.

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

*Specify:*

Electronic documents of the Plan of Care/Cost Comparison Budget are maintained in the operating agency's data system.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case Managers are responsible for the implementation and monitoring of the service plan and participant health and welfare. A minimum of one face-to-face contact between the case manager and the participant is required every 90 days, and as frequently as needed to support the participant. In each meeting, the participant's support team will review current concerns, progress and implementation of the plan of care.

In addition, there are required pieces of information that must be documented every 90 days. This is referred to as the 90 Day Checklist. With each completion of the 90 Day Checklist, the Case Manager and Individualized Support Team will cover in detail the status of the Cost Comparison Budget, the Individualized Support Plan, any behavioral support program, choice and rights, medical needs, medications, psychotropic medications, seizure management (if applicable), nutritional/dining needs, health and welfare, incident review, staffing issues, fiscal issues, and any other issues which may be identified in regard to the satisfaction of the participant. The checklist is also used to verify that emergency contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and the Bureau of Quality Improvement Services. Case Managers educate the participant by offering examples of when the emergency contact numbers should be called.

The entire process of utilizing the 90 Day Checklist is under review for consideration of potential enhancement. The original process has been changed to incorporate interviews with the participant prior to the annual meeting wherein

the participant is asked about his/her satisfaction with current services. Following the participant interview, the entire support team will meet to ensure everything is in place for the participant. These changes and any future enhancements will assure that the 90 day review is as meaningful as possible.

The case manager is required to enter a weekly case note indicating the progress and implementation of the plan of care. The case manager also maintains regular contact with the participant, family/guardian and the provider(s) of services through home and community visits or by phone to coordinate care, monitor progress and address any immediate needs. During each of these contacts the case manager assesses the plan of care implementation as well as monitors the participant's needs.

The monitoring and follow up method used by the case manager include conversations with the participant, the parent/guardian, and providers to monitor the frequency and effectiveness of the services through monthly team meetings and regular face-to-face and phone contacts. The case manager asks:

•Are the services being rendered per the plan of care?
•Are the service needs of the participant being met?
•Do participants exercise freedom of choice of providers?
•What is the effectiveness of crisis and back up plans?
•Is the participant's health and welfare being assured?
•Do participants have access to non-waiver services identified in the plan of care including access to health services?

The implementation and effectiveness of the plan of care is reviewed in quarterly team meetings.

A monitoring report has been developed by the contractor of case management services and is sent to the DDRS Case Management Liaison, DDRS management staff and to the Office of Medicaid Policy and Planning (OMPP) on a quarterly basis for review. At all times, full, immediate and unrestricted access to the individual data shall be available to the State, including the DDRS Case Management Liaison position as well as other members of the DDRS Executive Management Team and OMPP.

Using the Comprehensive Survey Tool (CST), approximately 363 DD Waiver service plans will be reviewed annually by the Bureau of Quality Improvement Services to assure consistency of waiver Plan of Care/Cost Comparison Budget with the Individualized Support Plan. Details of the CST are explained in Appendix G.

Problems regarding services provided to participants are targeted for follow up and remediation by the case management provider in the following manner:

- Case Managers conduct a face-to-face visit with each participant no less frequently than every 90 days, and complete a 90 Day Review Checklist at that time.
- They investigate the quality of participant services, and indicate on the checklist if any problems related to participant services are not in place.
- For each identified problem, they identify the timeframe and person responsible for corrective action, communicate this information to the interdisciplinary team, and monitor to ensure that corrective action takes place by the designated deadline.
- Case Manager Supervisors and District Directors within the case management organization monitor each problem quarterly via the State Hot List system to ensure that case managers are following up on, and closing out, any pending corrective actions for identified problems.

At least every 90 days, in conjunction with the 90 Day Review Checklist, Case Managers update the participant's Individualized Support Plan (ISP) progress notes, to indicate if all providers and other team members are current and accurate in their implementation of plan activities on behalf of the participant.

Any lack of compliance on the part of provider entities or other team members is noted within the participant's Participant Outcome Measurement Tool (COMT), and communicated to the noncompliant entity for resolution. Case Manager Supervisors and District Directors monitor this tool on no less than a monthly basis to ensure follow up and completion of all identified outcomes for each participant.

Upon receipt of a complaint from a participant or a reporter acting on a participant's behalf, the case manager investigates, and provides the participant and reporter with a determination of findings within two weeks of the date of receipt of the complaint. That determination is to be provided in writing and in the participant's usual mode of communication. If the allegation is of abuse, neglect, exploitation, mistreatment of a participant, or violation of a participant's rights, case managers take all necessary steps to ensure the safety of the participant. They review all filed

incident reports, work with the provider to file any missing reports, and file all needed follow up reports at seven (7)-day intervals until the situation is determined to be closed by the Division of Disability and Rehabilitative Services (DDRS). The Case Manager Supervisor and District Directors monitor the timeliness of follow up on incident reports by the case managers.

Upon receipt of information regarding ongoing, systemic behaviors on the part of a provider of service that are not in accordance with established standards of practice, the Case Manager will:

•Attempt to resolve the issue verbally with the provider in question
•If no resolution is made, put the issue in writing to the provider
•If then no resolution is made, bring the issue to the attention of the local Bureau of Developmental Disabilities (BDDS) Service Coordinator
•If there is still no resolution, file an incident report with the DDRS

Problems as identified within the 90 Day Review Checklist are reviewed for follow up and closure a minimum of quarterly by the Case Manager Supervisors and District Directors. Issues are initially addressed within the scope of the team and provider agency, and are escalated to the DDRS via mediation with the BDDS Service Coordinator, or via an incident report should the problems prove to be systemic and/or otherwise not resolvable at the case management level.

Untimely and/or incomplete progress as indicated on the COMT progress note system are reviewed monthly by the Case Manager Supervisors and District Directors. Issues are initially addressed within the scope of the team and provider agency, and are escalated to the DDRS via mediation with the BDDS Service Coordinator, or via an Incident Report should the problems prove to be systemic and/or otherwise not resolvable at the case management level.

Any identified problems related to the health and safe of a participant, or that involves real or alleged abuse, neglect, exploitation, mistreatment of a participant, or violation of a participant's rights are reported to the DDRS via the state Incident Reporting system.

**b. Monitoring Safeguards.** *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of sampled participants'support teams who gather information about the participants' preferences, personal goals, needs and abilities to develop the particpants' support plans. Denominator: The total number of particpants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| | |
|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Numerator: The total number of sampled participants who are supported to develop support plans that address their identifed needs, wants, and preferences.**
**Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|

| *that applies):* | |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of sampled participants who are supported to develop support plans what address identified needs, wants, and preferences.**
**Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of sampled participants who have support plans that are modified when there are changes in ability, needs, desires or circumstances. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| |
|---|
| ☑ **Continuously and Ongoing** |
| ☐ **Other**<br>Specify: |

**Performance Measure:**
**Support Plans are updated/revised at least annually. Numerator: The total number of particpants receiving services. Denominator: The total number of Support Plans updated annually.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| | |

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|---|---|
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of sampled particpants who receive the necessary assistance and coordination to consistently obtain the services and supports in their support plans. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe |

| | | |
|---|---|---|
| | | Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled particpants who receive continuous and consistent services and supports from each of their providers. Denominator: The total number of particpants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
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|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled particpants who have providers with necessary systems and supplies to implement particpants' support plans.**
**Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| *(check each that applies):* | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Numerator: The total number of sampled particpants who have information in their personal file that promotes continuity and consistency of services.**
**Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| | |
|---|---|
| | |

**Performance Measure:**
**Numerator: The total number of Consumer Outcome Measument Tools that accurately reflect the team meeting. Denominator: The total number of partipants receiving DD Wiaver Services.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Consumer Outcome Measurement Tool (COMT)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: Contractor of Case Management Services | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** | ☐ **Annually** |

| | |
|---|---|
| Specify:<br>Contractor of Case Management Services | |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Numerator: The total number of times Person Centered Plan/Participantized Support Plan reviewed and approved by participant. Denominator: Total number of particpants receiving DD Waiver services.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Consumer Outcome Measurement Tool (COMT)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Contractor of Case Management services | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|

| *that applies):* | |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Contractor of Case Management services | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**e.** ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of sampled participants who chose their waiver services. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 5% |
| | | |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Numerator: The total number of sampled particpants' support teams, which include case managers who support participants to select their providers.**
**Denominator: The total number of particpants.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100%** |

| | | |
|---|---|---|
| | | **Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information

on the methods used by the State to document these items.
As identified in the subassurances of this appendix the BQIS comprehensive survey tool (CST) includes performance indicators related to participant planning and service delivery. The CST contains a total of 35 performance indicators which each represent a set of related waiver regulations. Indicators are designed to provide a signal as to how the waiver service delivery system is impacting the participant. BQIS selects a random sample of participants to participate in the review process. When surveyors identify that an indicator is not met for a particular sampled participant the provider(s) is required to develop a corrective action plan to address the issue. BQIS reviews and approves corrective action plans and validates that providers are implementing these as stated. Providers have two opportunities to develop acceptable corrective action plans. Providers that are noncompliant or that do not implement their corrective actions as stated are referred to the BQIS and BDDS Directors. Follow-up action may include being referred to the sanctions committee.

All survey information will be included in the web-based automated system that the state is currently building to support the survey process. As an interim measure for collecting information BQIS has built and is using an Access database to track and maintain review findings. When the automated system is fully operational providers will be able to access the system to insert their corrective actions directly into the database.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br><br>Cantractor of Case Management services | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the Bureau of Developmental Disabilities Services' (BDDS) Intake and Assessment Process, the applicant for services under the Developmental Disabilities Waiver (or his/her legal representative) shall be advised of all available service options as well as their appeal rights at each decision. The BDDS Service Coordinator (SC) provides Intake Case Management Services, which includes offering an eligible applicant the feasible alternatives available under the DD Waiver and the choice between institutionalization or home and community-based services as described in Appendix B-7a.

Following is a description of how the individual (and/or legal representative) is offered the opportunity to request a Fair Hearing under 42 CFR PART 431, SUBPART E:

The Notice of Action (State Form 46015 Form 5): Federal regulations for the Medicaid program (42 CFR 431.200) require that each Medicaid applicant/participant be informed of any action that affects the applicant/participant or prospective participant's Medicaid benefits.

An "Action" may be a termination, reduction, or suspension of eligibility or any amount of covered services. This also includes actions taken to approve or deny new applicants as well as the choice of waiver or institutional services and the choice of providers. State Form 46015 Form 5 is used to notify each Medicaid Waiver applicant/participant of any action that affects the applicant/participant or prospective participant's Medicaid Waiver benefits.

An explanation regarding a waiver service applicant/participant or prospective participant's appeal rights and the opportunity for a fair hearing is found on the back of the form. Part 2 "Your Right to Appeal and Have a Fair Hearing" advises applicant/participant or prospective participant of his/her right to appeal and the timely actions which are required. Part 3

"How to Request an Appeal" provides instructions regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative or other spokesperson on behalf of the appellant.

Once an applicant enters the waiver program as a participant, the participant retains the same appeal rights and right to a Fair Hearing as described above. The participant shall be advised of the Right to Appeal and have a Fair Hearing by the Case Manager (CM) employed by the contracting case management entity.

The CM shall provide each participant and eligible prospective participant (as well as his or her guardian or advocate, as appropriate) with a copy of the Notice of Right to Appeal and have a Fair Hearing. The notice shall be immediately provided to the prospective participant when he/she is not provided the choice of home and community-based services as an alternative to institutional care, when he/she is denied the service(s) or the provider(s) of his/her choice, or when actions are taken to deny, suspend, reduce or terminate services.

The waiver Notice of Action informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 30 days of the decision date noted on the Notice of Action.

Upon request, the CM shall assist the eligible participant in preparing the written request for Appeal and Fair Hearing. Timeframes, the address for submission of the appeal, and an opportunity to discuss the issue being appealed shall be offered to the eligible participant by the CM. The request for an Appeal and a Fair Hearing is recorded in a Case Note by the contracting entity as well as being recorded at the Family and Social Services Administration's Hearing and Appeals office.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Indiana Division of Disability and Rehabilitative Services (DDRS) operates a separate dispute resolution process in addition to the formal, federally required Hearings and Appeals process towards addressing participant disputes or disputes involving the needs of the participant. In general, this process is available when there are disagreements about service provision. Resolution of the dispute is designed to address the participant's needs. Any issues that involve a participant's health and welfare do not go through this process, but are immediately referred to the Bureau of Quality Improvement Services (BQIS) for action.

The Indiana Administrative Code 460 IAC 6-10-8, "Resolution of Disputes" clarifies the responsibilities and timeframes for all parties involved in a dispute. It is recognized that this process was designed to handle disputes between providers, however, in those situations where the Individualized Support Team (IST) cannot come to agreement on how best to meet the needs of the participant, the Dispute Resolution process is available.

The beginning point of this process is the IST meeting in which involved parties are required to submit their issues in writing to the team. If providers on the Team are in agreement, and the participant or family member is not, the Case Manager (CM) must represent the participant in the Dispute Resolution process. If the team is unable to come to agreement on a decision within fifteen days, the dispute is referred to the appropriate Bureau of Developmental Disabilities (BDDS) Service Coordinator (SC) within the DDRS. The guiding standards for the SC in settling disputes will be the outcomes established for the participant in the Individualized Support Plan (ISP) and the health and welfare needs of the participant.

The SC is required to make a decision on the issue within fifteen days of the referral. Written notice is given to relevant parties. Any party adversely affected by the decision may request DDRS Administrative Review of the decision. While the dispute resolution process is available for teams to use, it is not required before a participant or guardian can file the request for a Medicaid Fair Hearing. As noted within 460 IAC 6-19-4 Distribution of information and 6-19-6 Monitoring of services, the CM is responsible for the monitoring of services and ensuring that the participant understands that the dispute process is in no way a pre-requisite or substitute of the participant's right to Appeal or request a Fair Hearing.

Unilateral decisions about service provision restrict the creative abilities of the IST to design a plan of care that recognizes the realities of everyday life, including the limited financial resources available from the State, to maximize the ability of the participant to achieve his/her outcomes. The IST, and not any one member, must drive decisions related to change in service. However, neither should any single member of the team unilaterally refuse to agree to changes in the plan. Any service changes that occur must be done in accordance with the direction and agreement of the IST.

If it is determined a provider's unilateral actions have endangered the health or welfare of a participant such that an emergency exists, BDDS will take action as described in rule 460 IAC 6-7-4, "Serious Endangerment of the Individual's Health and Safety (Welfare)".

# Appendix F: Participant-Rights

## Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The operating agency, the Division of Disability and Rehabilitative Services (DDRS), operates a separate complaint process system through the Bureau of Quality Improvement Services (BQIS) [established in Indiana Code, IC 12-12.5] in conjunction with the Bureau of Developmental Disabilities Services (BDDS) [established in IC 12-11-1.1] and in addition to the formal, federally required Hearings and Appeals process.

Satisfying the requirements of Indiana Code [IC 12-11-13], the operating agency, DDRS, also employs a statewide waiver ombudsman, independent of both the BQIS and the BDDS, for the benefit of participants with a developmental disability who are receiving services under the waiver and wish to file a complaint.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

PART 1:

(a)The Bureau of Quality Improvement Services (BQIS) accepts a broad range of complaints; because the complaint system is not meant to replace the state's system for reporting and investigating incident reports, any issue that does not meet the definition of a reportable incident can be registered as a complaint. If the individual receiving the complaint identifies that the issue is reportable BQIS will assure that an incident report is filed either by directing the complainant to do so (if complainant is a provider, service coordinator, or case manager) or by completing the report independently. If warranted, Adult Protective Services and or Protection and Advocacy offices are notified of the complaints. On occasion and whenever necessary, BQIS partners in conjunction with these two offices to resolve issues/complaints.

Note that complaints having to do with group homes (ICR/MRs) are immediately forwarded to ISDH to investigate since BQIS does not have oversight authority for people in these residential settings.

The individual initially receiving a complaint determines whether the case manager, provider and/or local BDDS District Office have been made aware of the perceived problem, and given an opportunity to resolve the issue. If not, the complainant is referred to the appropriate entity (case manager, BDDS service coordinator, etc.). If appropriate entities have had opportunities for resolution but the issue remains problematic, the issue is considered a complaint.

The BQIS Quality Assurance Director reviews all initial complaints and determines the severity/urgency of the issues to be investigated. Types of complaints received by BQIS are categorized as urgent, critical, or non-critical and are addressed in that order. Examples of an urgent complaint could consist of allegations of abuse, neglect, or exploitation. Those listed under critical might be issues dealing with health and safety, misuse or misappropriation of funds or environmental issues. Non-critical complaints often consist of service related issues.

(b)Due to very limited staffing available to investigate complaints BQIS has not defined specific timeframes for investigating complaints and following-up on providers' corrective action plans. Upon receipt of a complaint the BQIS Director and/or the BQIS Quality Assurance Director determine the severity of the issue and identify a timeframe for completing reviews. The BQIS Quality Assurance Director assigns a Quality Assurance Monitor (QAM) to investigate and enter this information into the complaint database.

(c)Depending on the nature of the complaint QAMs investigation activities could include:

•Conducting site visits to the participants' home and/or day program site.
•Conducting one-on-one interviews with the participant receiving services and/or their staff, guardians, family members and any other people involved in the issue being investigated as deemed appropriate by BQIS.
•Requesting and reviewing of documents/information from involved providers.
All investigation activities are entered into the complaints database.

QAMs develop a findings report that includes a description of the review activities that they performed and the resulting outcomes. If issues are validated, QAMs direct providers to develop a corrective action plan and provide a due date. During this process, the QAM and or the Director of Quality Assurance will provide technical assistance which may include interpretation of regulations or information regarding assistance available to the provider, such as Outreach Services. The findings report and request for corrective action are emailed to the provider in the form of a letter followed by a hard copy sent via US mail. The BQIS Director is carbon copied on all written interactions with providers.

Once the QAM receives the Corrective Action Plan (CAP), it is reviewed to determine its acceptability. If accepted, the QAM notifies the provider of the acceptance and the process for validation. If the submitted CAP is not accepted, the QAM provides the provider with an explanation of what is unacceptable and why. The provider is then requested to re-submit the CAP with the appropriate changes. The re-submitted CAP is then reviewed for acceptance again and the provider is notified of the results. The QAMs validate that the provider is implementing the CAP as it is written and that involved participant(s) are experiencing positive outcomes as a result. Validation activities will vary depending on the specific issues under investigation and identified in the CAP but may include:

•conducting site visits
•conducting interviews with involved participant(s) and/or staff, guardians, family members, and any other involved entities
•review of participant(s) case record (i.e., individual service plan, behavior support plans, supporting tracking forms, risk plans, medication administration records,
•review of provider policy and procedures

QAMs document all validation activities and their resulting outcomes in the complaint database.

QAMs communicate to providers the results of their validation review through a letter sent electronically followed by a hard copy sent via US mail. This correspondence will indicate when all issues have been addressed and validated. The QAM will then update the complaint database to indicate that the complaint has been closed. Conversely when issues cannot be validated, QAMs will direct providers as to what needs to be accomplished for the corrective action plan to be closed. The BQIS Director and the BQIS Quality Assurance Director are carbon copied on all correspondence. Providers that are non-compliant or that continually fail to implement corrective action plans risk being referred to the sanctions committee for possible sanctions.

PART 2:

The role of the statewide waiver ombudsman is to receive, investigate and attempt to resolve complaints and concerns that are made by or on behalf of individuals who have a developmental disability and who receive services under a waiver under the home and community-based services program. Complaints received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral to the statewide waiver ombudsman include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, complaints requiring coordination between legal services, operating agency services and provider services.

The ombudsman is expected to initiate contact with the complainant as soon as possible once the complaint is received. However, precise timelines for the final resolution of each complaint are not established. While it is expected that the ombudsman diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary. Timeframes toward complaint resolution vary in accordance with the required research, in the collection of evidence and in the numbers and availability of persons who must be contacted, interviewed, or brought together toward the resolution of the complaint. Therefore, specific timelines for resolution of each complaint are not assigned. The DDRS Director is responsible for oversight of the statewide waiver ombudsman.

With the consent of the participant having a developmental disability, the statewide waiver ombudsman must be provided access to the participant, any entity that provides services to the participant and records of the participant, including records held by the entity providing services to the participant. When the participant is determined by the attending physician or by state law to be incapable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the participant's legal representative.

A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability and from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.

A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman shall provide the ombudsman with access to the records.

The statewide waiver ombudsman shall promote effective coordination among the programs that provide legal services for individuals with a developmental disability, the operating agency, providers of waiver services to individuals with developmental disabilities, and providers of other necessary or appropriate services; and ensure that the identity of the participant will not be disclosed without either the participant's written consent or a court order.

At the conclusion of an investigation of a complaint, the ombudsman shall report the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman shall notify the complainant of the decision not to investigate and reasons for the decision.

The statewide waiver ombudsman shall prepare a report at least annually (or upon request) on the operations of the program. A copy of the report shall be provided to the governor, the legislative council, the operating agency and the members of the Indiana Commission on Mental Retardation and Developmental Disabilities. Note that trends are identified so that recommendations for needed changes in the service delivery system can be implemented.

The operating agency is required to maintain a statewide toll free telephone line continuously open to receive complaints regarding waiver participants with developmental disabilities. All complaints received from the toll free line must be forwarded to the statewide waiver ombudsman, who will advise the participant that the complaint process is not a pre-requisite or a substitute of a Medicaid Fair Hearing when the problem falls under the scope of the Medicaid Fair Hearing process described in Appendix F-1.

A person who intentionally prevents the work of the ombudsman, knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation or a potential investigation; or knowingly or intentionally retaliates against a resident, a client, an employee, or another person who files a complaint or provides information to the ombudsman; commits a Class B misdemeanor.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As indicated in Bureau of Developmental Disabilities Services (BDDS) Incident Management/Reporting Policy, reportable incidents are any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to a participant or death of a participant. Specific critical incidents that must be reported are as follows:

1)Alleged, suspected or actual abuse, neglect or exploitation of a participant. An incident in this category must also be reported to Adult Protective Services or Child Protective Services. In cases where staff is involved, the provider shall suspend staff involved in an incident from duty pending investigation by the provider.

a)Physical abuse includes:
i) intentionally touching another person in a rude, insolent or angry manner;
ii) willful infliction of injury;
iii) unauthorized restraint or confinement resulting from physical or chemical interventions;
iv) rape.

b)Verbal and Psychological abuse includes:
i) communicating with words or actions directed to or made about a participant in that person's presence with the intent to:
a) cause the person to act against their will;
b) cause the person to be placed in fear of retaliation;
c) cause injury to the person or cause damage to the person's property;
d) cause the person to be subject to confinement or restraint;
e) cause the person to react in a negative manner; or
f) cause hatred, contempt, disgrace, humiliation, emotional distress or ridicule to the person.

c)Sexual abuse includes unwanted or forced sexual activity, sexual molestation, sexual misconduct, sexual coercion and sexual exploitation.

d)Domestic abuse occurs when a spouse, cohabitant/non-married intimate partner attempts to physically or psychologically dominate another. Domestic violence includies physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation, and threats of violence.

e)Neglect includes but is not limited to failure to provide appropriate supervision, training, clean and sanitary environment, appropriate personal care, food, medical services including routine medical and specialty consultations, or medical supplies or safety devices to a participant as indicated in the Participant's Plan.

f)Exploitation includes but is not limited to unauthorized use of the personal services, the property or the identity of a participant; any other type of criminal exploitation for one's own profit or advantage or for the profit or advantage of another.

g)Peer to peer aggression includes willful intent to inflict physical harm.

2)Death of a participant. All deaths must be reported to Adult Protective Services or Child Protective Services. If the death is a result of alleged criminal activity, the death must be reported to law enforcement.

3)A service delivery site that jeopardizes the health or welfare of a participant while the participant is receiving services from the following causes:

a)A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm, carbon monoxide alarm or sprinkler system;

b)Environmental or structural problems associated with a service site that compromises the health or welfare of a participant, including but not limited to inadequate sanitation, serious lack of cleanliness, rodent or insect infestation, structural damage or failure, damage caused by flooding, tornado or other acts of nature, or environmental hazards such as toxic or noxious chemicals.

4)Fire, residential or service delivery site (e.g., day services), resulting in health or welfare concerns for a participant receiving services. This includes but is not limited to relocation, personal injury, or property loss.

5)Elopement of a participant that results in evasion of required supervision as described in the Participant's Plan as necessary for the participant's health and welfare.

6)Alleged or actual criminal activity by a participant receiving services and/or a direct support professional staff, employee, contractor or agent of a provider when the participant's services or care are affected or potentially affected; the activity occurred at a service site or during service activities; or the participant was present at the time of the activity.

7)Any physical symptom, medical or psychiatric condition or event requiring emergency intervention.

8)A new diagnosis of any chronic condition impacting the participant or requiring medical follow-up.

9)Injury to a participant when

a)The origin or cause of the injury is unknown;

b)The injury could be indicative of abuse, neglect or exploitation; or

c)The injury requires medical evaluation or treatment.

10)A significant injury to a participant including but not limited to:

a)Fracture;

b)Burn (including sunburn) requiring more than first aid;

c)Choking that requires intervention (including but not limited to Heimlich maneuver, finger sweep)

d)Contusions larger than a quarter or a pattern of contusions;

e)Lacerations which require more than basic first aid;

f)Any occurrence of skin breakdown related to any decubitus ulcer;

g)Any injury that occurs while a participant is restrained;

h)Any injury which requires more than basic first aid.

11)A medication error or medical treatment error, except for refusal to take medications, that jeopardizes a participant's health and welfare, as determined by the participant's personal physician including but not limited to the following:

a)Medication given or treatment provided that was not prescribed or ordered for the participant;

b)Failure to administer medication or medical treatment as prescribed.

12)Use of any PRN medication related to a participant's behavior.

13)Seclusion by placing a participant alone in a room or other area from which exit is prevented.

14)Prone restraint.

15)Aversive technique.

Anyone responsible for providing services and/or supports is required to report incidents. This includes but is not limited to the following:

- •Direct service providers (e.g., residential, day services, behavior support, etc.)
- •Case managers
- •BDDS staff
- •BQIS staff
- •Outreach staff
- •Crisis management staff

Incident reports are to be submitted within 24 hours of the occurrence of the incident or the reporter becoming aware of or receiving information about the incident.

BQIS uses a web-based system to report and manage incident reports. All incident reports are to be submitted using this web-based system but there is also an email address that is used as a back-up in the event of network malfunction. While providers encourage their staff to report incidents through their own internal systems, anyone with an internet connection can report an incident through the state's system.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Per Indiana waiver regulation 460 IAC 6-8-3, providers are required annually to educate participants on identifying and reporting incidents of abuse, neglect, and exploitation. When the Bureau of Quality Improvement Services (BQIS) conducts its comprehensive survey, information about whether this training occurred is assessed by talking with the participant and their family members. The expected outcome of a consumer receiving this training would be for the consumer to be able to 1) recognize when they are not being treated as they would like; and 2) communicate this information to someone to report it (i.e., family member, provider, case manager, BDDS service coordinator).

If a provider is identified to have not conducted this training the related performance indicator will not be met and the provider will be required to develop corrective actions subject to BQIS's review and approval. Surveyors validate that corrective action, which should include training, has in fact taken place.

In addition to provider training, at intake and annually case managers have discussions with consumers about how to identify and report abuse, neglect, and exploitation. At these meetings case managers provide participants a copy of the grievance procedure and "A GUIDE FOR INDIVIDUALS WORKING WITH THE BUREAU OF

DEVELOPMENTAL DISABILITIES SERVICES." This guide communicates to participants what their rights are as recipients (consumers) of waiver services. Examples of the participant (consumer) rights identified in the guide include:

- You have the right to be informed of your rights at least annually and in a manner in which you can understand.
- You have the right to be free from physical punishment and painful treatment.
- You have the right to be free from abuse, neglect, exploitation or mistreatment.
- You have the right to not be placed in a room or other area from which exit is prevented.
- You have the right to be treated with dignity and respect.

Participants are required to sign and date that they received the grievance procedure and BDDS guide to receiving services.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

BQIS is responsible for the oversight of the incident reporting system which includes receiving and evaluating all incident reports. Incident reviewers use the web-based incident reporting system to evaluate each of the incident reports to determine whether or not the provider has taken appropriate and sufficient actions to remedy the situation, prevent chances for reoccurrence, and to assure the participant's immediate safety. They also evaluate if incidents meet the criteria of being a sentinel event. If so, the incident reporting system automatically generates an e-mail to the participant's BDDS service coordinator and a designated distribution list to alert them of the incident and to indicate whether or not a follow-up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report.

To ensure the participant's health and welfare the BDDS service coordinator makes either face-to-face or phone contact with the provider within 24 hours of notification of the sentinel event and documents this interaction in the BDDS case notes portion of the incident reporting system. Sentinel status will remain unresolved until there is documentation in the BDDS case notes documenting that the provider took appropriate actions to resolve the issue. If immediate protective measures were included in the initial incident report, the BDDS service coordinator is not required to follow-up within 24 hours. They are however still notified of the incident and in most cases will contact the provider regarding the incident.

On a weekly basis the BQIS Incident Review/Risk Management Manager reviews all unresolved sentinel events. When documentation assuring health and welfare is confirmed the sentinel status is closed. The IR/RM Manager submits a weekly report of unresolved sentinel events to the BDDS and BQIS Directors and to the case management entity. The participant's case manager, along with input from the support team, is responsible for electronically submitting follow-up reports within seven days of the incident being reported and every seven days thereafter until the incident is resolved to the satisfaction of all entities.

Follow-up reports provide the necessary documentation of actions taken to address incident-related issues. To assist with this, reports of outstanding incident reports are sent to IPMG and residential providers on a monthly basis. Service coordinators ensure that case managers are completing required follow-up reports until incidents are considered closed. At BDDS' discretion service coordinators may conduct a quality site review of the participant's environment to ensure that the team's proposed measures to assure the participant's health and welfare are in place and appropriate.

BDDS service coordinators notify families/guardians of incidents reported and share the results of the provider's investigation.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

BQIS oversees incident reporting and management and works closely with BDDS to assure that the same incidents do not continue to occur. On a monthly basis the BQIS IR/RM Manager compiles aggregate incident data based on each of the incident types described in G-1-b of this waiver application. Reports identifying participants with "high" risk incidents are distributed to BDDS districts on a monthly basis for local risk management committees to analyze and remediate.

Reports are compiled by participant and by provider on the following "high risk" types of incident reports:
oArrest/Placement Removal
oSuicide Attempt
oElopement
oMedication Errors that jeopardize health and welfare, as determined by the participant's personal physician
oChoking Episodes Requiring Intervention
oFalls with Injury
oSeizures Resulting in ER/Hospital Visit
oBowel Impactions Resulting in ER/Hospital Visit
oDehydration Episodes Resulting in ER/Hospital Visit
oRespiratory Events Resulting in ER/Hospital Visit
oER Visits
oIn-Patient Hospitalizations, Medical
oIn-Patient Hospitalizations/ER Visits, Psychiatric
oUse of PRN Medications, Behavioral
oUse of Restrictive Techniques
oLack of Consumer Supports
oSentinel Events
oEnvironmental Risks
- Fire, Residential/Service Delivery Site
- Problems with Habitable Residence
- Problems with Uninhabitable Residence
oMultiple Reportable Incidents

BDDS district risk management meetings discuss participants who experience sentinel events and multiple incidents. Participants may be referred for ongoing follow up through the risk management process.

BQIS also oversees the mortality review process. All deaths are reviewed by BQIS's mortality review triage team. Deaths with suspect circumstances are reviewed by the full Mortality Review Committee (MRC). While the review of deaths takes place on an ongoing basis, the MRC meets monthly.

The BQIS Director facilitates the Quality Improvement Executive Committee (QIEC) where OMPP and all relevant DDRS entities (BQIS, BDDS, outreach and crisis teams, case management contract liaison) are encouraged to review their particular data for trends and to develop draft mitigation strategies that address the identified risk by preventing further occurrences. QIEC meeting time is dedicated to discussing and finalizing the specific plans for implementing the mitigation strategies.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

**a. Use of Restraints or Seclusion.** *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  **i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State allows the use of restraints when used in conjunction with a Behavioral Support Plan and approved by the Human Rights Committee or in an emergency situation “only to prevent significant harm to the individual or others.”

Indiana code applicable to waiver services does not differentiate between personal restraints, but includes them as “restrictive interventions” in its implementation of safeguards. Drugs used as a method of restraint are also addressed as a “restrictive intervention” while requiring additional safeguards. Seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

The State has established, through 460 Indiana Administrative Code (IAC) 6-9-3, "Prohibiting Violations of Individual Rights", provider standards prohibiting abuse, neglect, exploitation, or mistreatment of a participant, or violation a participant’s rights. Abuse is defined under 460 IAC 6-3-2, "Abuse", which includes “Unnecessary physical or chemical restraints or isolation". "Seclusion" by placing a participant alone in a room or other area from which exit is prevented is specifically prohibited from use under the rule. Also prohibited are practices which deny a participant any of the following without a physicians order: Sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities.

460 IAC 6-18-2, "Behavioral Support Plans", allows behavioral support plans which utilize restrictive interventions when the plan contains:

(1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed;
(2) documentation that the risks of the targeted behavior have been weighed against the risk of the highly restrictive procedure;
(3) documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective;
(4) documentation that the participant, the participant’s support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the participant or others;
(5) informed consent from the participant or the participant’s legal representative;
(6) documentation that the behavioral support plan is reviewed regularly by the participant’s support team.

To ensure the participant’s safety the participant’s support team participates in quarterly reviews with the behavioral support staff. This includes the participant, his/her parent or guardian, the BDDS service coordinator, case manager, and applicable service providers. The team reviews the behavioral clinician’s monthly reports, behavior data tracking sheets and verbal input from team members. The monthly report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

The state is committed to assuring the use of behavior modifying medication as a last resort, requiring the participant’s support team to be in agreement with the use of medication, and have the approval of the Human Rights Committee prior to implementation. Additional safeguards implemented when a psychoactive medication is administered on a PRN basis include:

(1) The behavioral support plan must include a hierarchy for obtaining administrative approval to administer the PRN medication, and a participantized protocol identifying the circumstances and conditions in which the PRN medication can be administered.
(2) The behavioral support plan must include a plan of desensitization addressing the situations that precipitate use of PRNs, such as medical visits and other situations that occur on a regular basis. The plan shall also include methods for staff to monitor and document the results of the desensitization process.
(3) Monitoring and documentation of PRN administration must include an analysis of the effectiveness of each incident of administration, as well as a description of events leading up to the PRN administration, including any desensitization methods and their results. Documentation must detail the approval process, the date, time, and dosage of administration, and include a description of the participant’s behavior after the administration, including any side effects or interactions with other medications.
(4) The Individualized Support Team must analyze and evaluate the effectiveness of PRN medication administration in eliminating targeted behaviors or symptoms, and address possible relationships between behavioral and medical issues. The Individualized Support Team must ensure that treatment is provided in the least restrictive manner possible and that desensitization methods have been utilized and documented per the behavioral support plan.

In an emergency, chemical restraint, physical restraint, or removal of a participant from the participant's environment may be used without the necessity of a behavioral support plan, but only to prevent harm to the participant or others. The participant's support team is then required to meet not later than five working days after the emergency chemical restraint, physical restraint, or removal of a participant from the environment in order to:

(1) Review the circumstances of the emergency chemical restraint, physical restraint, or removal of a participant;
(2) Determine the need for a functional analysis, behavioral support plan or both, and to document recommendations. If a provider of behavioral support services is not a member of the participant's support team, a provider of behavioral support services must be added to the participant's support team.

Indiana waiver regulation, 460 IAC 6-18-2, requires that providers' staff be trained to implement the participant's specific behavior plan. In addition to the oversight provided by the participant's support team and case manager, BQIS surveyors conduct comprehensive surveys for sampled participants. To assess that the participant's behavior support plan is being implemented correctly, surveyors interview the participant, talk with his/her providers, and review any behavior support plans and accompanying documentation. When there are issues identified surveyors will direct providers to develop corrective action plans. Participants' teams submit comprehensive corrective action plans to BQIS for review and approval. BQIS then validates that these plans are being implemented as stated.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

BQIS, BDDS, and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the participant level occurs through the Individualized Support Team and the case management function as contracted. Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, specifically through the required 90 day review. Additionally, comprehensive surveys conducted on participants address behavioral support services to assure that appropriate plans are in place and implemented correctly.

Data gathered through incident reporting, complaints, surveys, and mortality review is compiled by BQIS and reviewed monthly by district-level, local risk management committees. These committees are comprised of Outreach staff, BDDS, and a case manager representative. Their purpose is to analyze data to determine whether or not participants may face increased risk due to medical or behavioral issues. For each participant on the high-risk list, a risk assessment packet is sent to the participant's Individualized Support Team.

Upon completion of the risk assessment tool, outreach staff will review and identify risk issues, suggest protocols and additional assessment tools to assist the participant's Individualized Support Team in addressing potential risk issues. Individual situations, including the implementation of the protocols, are discussed in depth during subcommittee meetings of the District Risk Management Committees in an effort to identify next steps for the participant's Individualized Support Team to mitigate identified risk and prevent occurrence of incidents. Participant's names are added to, and removed from, the high-risk list during these monthly subcommittee meetings.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**b. Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions

and how this oversight is conducted and its frequency:

**The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State allows the use of restrictive interventions when used in conjunction with a Behavioral Support Plan, or in an emergency situation only to prevent harm to the participant or others. Behavior support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors.

460 Indiana Administrative Code (IAC) 6-18-2, "Behavioral Support Plans", allows behavioral support plans which utilize restrictive interventions when the plan contains:

(1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed;
(2) documentation that the risks of the targeted behavior have been weighed against the risk of the highly restrictive procedure;
(3) documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective;
(4) documentation that the participant, the participant's support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the participant or others;
(5) informed consent from the participant or the participant's legal representative;
(6) documentation that the behavioral support plan is reviewed regularly by the participant's support team.

The participant's support team participates in quarterly reviews with the behavioral support staff.
To ensure the participant's safety the participant's support team participates in quarterly reviews with the behavioral support staff. This includes the participant, his/her parent or guardian, the BDDS service coordinator, case manager, and applicable service providers. The team reviews the behavioral clinician's monthly reports, behavior data tracking sheets and verbal input from team members. The monthly report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

IN waiver regulation IAC 460-6-9-3 establishes a prohibition against violating participants' rights. Providers are directed to adopt policies and procedures that prohibit abuse, neglect, exploitation, and mistreatment of participants. Abuse is defined in 460 IAC 6-3-2 to include unnecessary physical or chemical restraints or isolation. Also prohibited are practices which deny a participant any of the following without a physicians order: Sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

BQIS, BDDS, and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the participant level occurs through the Individualized Support Team and the case management function as contracted.

Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, specifically through the required 90 day review. Additionally, comprehensive surveys conducted on participants address behavioral support services to assure that appropriate plans are in place and implemented correctly.

Data gathered through incident reporting, complaints, surveys, and mortality review is compiled by BQIS

and reviewed monthly by district-level, local risk management committees. These committees are comprised of Outreach staff, BDDS, and a case manager representative. Their purpose is to analyze data to determine whether or not participants may face increased risk due to medical or behavioral issues.

For each participant on the high-risk list, a risk assessment packet is sent to the participant's Individualized Support Team. Upon completion of the risk assessment tool, outreach staff will review and identify risk issues, suggest protocols and additional assessment tools to assist the participant's Individualized Support Team in addressing potential risk issues.

Individual situations, including the implementation of the protocols, are discussed in depth during subcommittee meetings of the District Risk Management Committees in an effort to identify next steps for the participant's Individualized Support Team to mitigate identified risk and prevent occurrence of incidents. Participant's names are added to, and removed from, the high-risk list during these monthly subcommittee meetings.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Participants in the Developmental Disabilities Waiver program are served in a variety of settings. The participant or organization identified in the Individualized Support Plan is responsible for coordinating the participant's health care. This includes coordinating the participant's annual physical dental and vision examinations ordered by the physician, routine examinations and screenings, and referrals to specialists (460 IAC 6-25-2).

A significant part of coordinating health care includes needing to document the services the person has received. Providers with this responsibility need to maintain the dates of health and medical services, a description of those services and an organized system for documenting that medications are administered (460 IAC 6-25-3).

The system for medication administration must include a documentation system, a system for communicating among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health related reportable incident – of which one is medication errors (460 IAC 6-25-9).

Case managers conduct 90-day visits to, in addition to other things, monitor providers' compliance with medication administration systems. The purpose of this monitoring is to detect potentially harmful practices and then to follow-up to address these practices. Case managers use a standardized checklist to conduct these monitoring visits. The incident reporting and complaint processes provide an additional monitoring resource.

When behavior modifying medications are used, the state mandates the participant's support team to be in agreement with the use of medication and have the approval of the Human Rights Committee prior to implementation. Additional safeguards implemented when a psychoactive medication is administered on a pro re nata (PRN "as needed") basis include:

1) The behavioral support plan must include a hierarchy for obtaining administrative approval to administer the PRN medication and an individualized protocol identifying the circumstances and conditions in which the PRN medication can be administered.

2) The behavioral support plan must include a plan of desensitization addressing the situations that precipitate use of PRNs, such as medical visits and other situations that occur on a regular basis. The plan shall also include methods for staff to monitor and document the results of the desensitization process.

3) Monitoring and documentation of PRN administration must include an analysis of the effectiveness of each incident of administration as well as a description of events leading up to the PRN administration, including any desensitization methods and their results. Documentation must detail the approval process, the date, time, and dosage of administration and include a description of the participant's behavior after the administration, including any side effects or interactions with other medications.

4) The Individualized Support Team must analyze and evaluate the effectiveness of PRN medication administration in eliminating targeted behaviors or symptoms and address possible relationships between behavioral and medical issues. The Individualized Support Team must ensure that treatment is provided in the least restrictive manner possible and that desensitization methods have been utilized and documented per the behavioral support plan.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Through 460 IAC 6-25-4, "Organized System for Medication Administration Required", the State requires providers have an organized system for medication administration for each participant receiving medications. The provider shall document the system in writing and distribute the document to all providers administering medication to the participant. The documentation shall be placed in the participant's file maintained by all providers administering medication to the participant.
This required system shall contain at least the following elements:

•Identification and description of each medication required for the participant;

•Documentation that the participant's medication is administered only by trained and authorized personnel unless the participant is capable of self-administration of medication as provided for in the participant's, Individualized Service Plan (ISP);

•Documentation of the administration of medication, including administration of medication from original labeled prescription containers; the name of medication administered; the amount of medication administered; the date and time of administration; and the initials of the person administering the medication.

•The system must also include procedures for the destruction of unused medication;

•Documentation of medication administration errors;

•A system for the prevention or minimization of medication administration errors.

•When indicated as necessary by a participant's ISP, procedures for the storage of medication;

•Documentation of a participant's refusal to take medication;

•A system for communication among all providers that administer medication to a participant.

•All providers administering medication to the participant shall implement and comply with the organized system of medication administration designed by the provider.

BQIS, BDDS, and OMPP are all responsible for monitoring medication management practices through incident reporting, the BQIS survey process, mortality review, the complaint process, and anecdotal information presented through the risk management committee framework. The case management entity and BDDS analyze data at the participant level, identify trends, and work with providers to develop remediation plans.

BQIS conducts the same activities but for provider-specific and systemic trend analysis. Relevant DDRS entities (BDDS, BQIS, outreach, crisis, case management entities) also use the QIEC system to develop and implement mitigation strategies to address potentially harmful practices and improve quality.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana waiver regulation, 460 IAC 6-14-4, requires that all staff be trained in administering medication. The state has an approved curriculum available for providers to use to conduct this training.

460-IAC 6-25-3, "Documentation of Health Care Services Received by an individual", addresses the state's rules for medication administration and also includes the need for providers to maintain the dates of health and medical services, a description of those services and the need for an organized system for medication administration.

The system for medication administration must include a documentation system, a system for communication among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health related reportable incident – of which one is medication errors (IAC 6-25-9, "Health Related Incident Management").

Under 460 IAC 6-10-10, "Quality Assurance and Quality Improvement System", providers administering medications are required to have a quality assurance and quality improvement process to analyze medication errors, develop recommendations to reduce the risk of future errors, and review recommendations to assess for effectiveness.

Incident reporting policies require medication errors to be reported to BDDS as addressed under 460 IAC 6-9-5, "Incident Reporting".

**iii. Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  *Complete the following three items:*

  (a) Specify State agency (or agencies) to which errors are reported:

  Medication errors must be reported to BDDS through the incident reporting process under IAC 6-9-5, "Incident Reporting" and detailed within Appendix G-1-a of this application.

  (b) Specify the types of medication errors that providers are required to *record:*

  The types of medication errors required to be recorded are:
  1) Wrong medication given that places a participant's health and welfare in jeopardy as determined by the personal physician.
  2) Wrong dose given that places the participant's health and welfare in jeopardy as determined by the personal physician.
  3) Missed medication that places the participant's health and welfare in jeopardy as determined by the personal physician.
  4) Medication given outside the prescribed administrative window that jeopardizes a participant's health and welfare as determined by the personal physician.
  So that providers can conduct their own medication administration training, DDRS has an approved Core A and B medication administration training curriculum available to assist providers' trainers. The state requires that only RN or LPNs participates in this train-the-trainer training.

(c) Specify the types of medication errors that providers must *report* to the State:

The types of medication errors required to be reported through the incident reporting process under IAC 6-9-5, "Incident Reporting", are:

1) Wrong medication given that places a participant's health and welfare in jeopardy as determined by the personal physician.

2) Wrong dose given that places the participant's health and welfare in jeopardy as determined by the personal physician.

3) Missed medication that places the participant's health and welfare in jeopardy as determined by the personal physician. (Refusal to take medications does not require filing of an incident report but should be followed up by medical personnel and the interdisciplinary team to ensure that the health and welfare of the participant is safeguarded. This information should also be documented in the participant's record).

(4) Medication given outside the prescribed administrative window that jeopardizes a participant's health and welfare as determined by the personal physician.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

BQIS, BDDS, and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the participant level occurs through the Individualized Support Team and the case management function as contracted. Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, specifically through the required 90 day review. Additionally, comprehensive surveys conducted on participants address behavioral support services to assure that appropriate plans are in place and implemented correctly.

Data gathered through incident reporting, complaints, surveys, and mortality review is compiled by BQIS and reviewed monthly by district-level, local risk management committees. These committees are comprised of Outreach staff, BDDS, and a case manager representative. Their purpose is to analyze data to determine whether or not participants may face increased risk due to medical or behavioral issues.

For each participant on the high-risk list, a risk assessment packet is sent to the participant's Individualized Support Team. Upon completion of the risk assessment tool, outreach staff will review and identify risk issues, suggest protocols and additional assessment tools to assist the participant's Individualized Support Team in addressing potential risk issues.

Individual situations, including the implementation of the protocols, are discussed in depth during subcommittee meetings of the District Risk Management Committees in an effort to identify next steps for the participant's Individualized Support Team to mitigate identified risk and prevent occurrence of incidents. Participant's names are added to, and removed from, the high-risk list during these monthly subcommittee meetings.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**
***The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Numerator: The total number of participants with providers who implement policies and procedures that define, prohibit and prevent; abuse, neglect, mistreatment and exploitation. Denominator: The total number of participants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation** | **Frequency of data aggregation and** |
|---|---|

| **and analysis** *(check each that applies):* | **analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Numerator: The total number of sampled particpants with support staff who know how to prevent, detect and report allegations of abuse, neglect, mistreatment and exploitation.**
**Denominator: The total number of particpants sampled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Comprehensive Survey Tool (CST)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

On a weekly basis the BQIS Incident Review/Risk Management Manager reviews all unresolved sentinel events. When documentation assuring health and welfare is confirmed the sentinel status is closed. The IR/RM Manager submits a weekly report of unresolved sentinel events to the BDDS and BQIS Directors and the case management entity. The participant's case manager is responsible for electronically submitting follow-up reports within seven days of the incident being reported and every seven days thereafter until the incident is resolved to the satisfaction of all entities. Follow-up reports provide the necessary documentation of actions taken to address incident-related issues. To assist with this, reports of outstanding incident reports are sent to the case management entity and residential providers on a monthly basis.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |

☑ **Continuously and Ongoing**

☐ **Other**
Specify:

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent

*roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

BQIS is in the process of designing a three-tier quality improvement strategy for addressing person-specific, provider-specific, and systemic trends based on data and information from:

- incident reports,
- the mortality review committee,
- BQIS comprehensive survey findings,
- transition monitoring reviews,
- financial reviews,
- complaints and investigations,
- outreach and crisis teams.

Data and information from all of these sources will help DDRS maximize its resources to improve the quality of services at all levels of our system.

At this point in time our strongest data sources are incident reporting and mortality review so we primarily identify areas that warrant improvement from these two sources. BQIS has undertaken a major effort to redesign its processes and tools structured around the CMS Quality Framework to make them more individual-outcome focused. While new monitoring activities have started only recently these new data sources are feeding into our system and will allow us to make better management decisions.

Tier I – Participant-Specific Issues
Case managers have the front-line responsibility for monitoring participants and following-up on issues identified through their routine contacts with the participant.

The BQIS Incident Reporting/Risk Management Manager (IR/RM) Manager aggregates and analyzes incident data on a monthly basis and generates reports for each BDDS district. Based on volume of incidents, repeated incidents, incidents severely jeopardizing health and welfare, recommendations are made for individuals to be placed on BDDS high risk list for additional attention. All recommendations are discussed in BDDS local risk management committees and service coordinators take actions to assure the participant's safety.

Tier II – Provider-Specific Issues
BQIS and BDDS address provider-specific risk trends. Issues are identified from a variety of internal and external stakeholders that result in BQIS conducting complaint investigations. For example, incident report or mortality review data may indicate that a particular provider is having difficulty with an issue and several individuals have been impacted. Outreach and/or crisis team monthly data reports could also indicate a provider-specific trend. A family member, neighbor, former provider staff may identify areas where a

provider is not performing for participants, e.g., for multiple homes respite staff not reporting for duty as assigned. BQIS focuses on the particular issue in conducting a review of the situation and directing the provider to develop corrective actions for making improvements. In some instances BQIS may direct the provider to conduct its own investigation and implement corrective actions accordingly.

BDDS provider relations and service coordinators provide technical assistance to providers by helping them improve their policies and operating procedures. This can be both proactive and reactive depending on how assistance is initiated. BDDS provider relations supports entities pursuing becoming waiver providers by reviewing and making recommendations on policies and procedures submitted as part of the application process. Based upon issues identified in their reviews, BDDS provider relations could provide assistance for a variety of issues, i.e, how the entity plans to monitor the quality of its services or set up their internal process for investigating incidents of abuse and neglect. BDDS service coordinators assist established providers when problems have already occurred and the provider needs to address the situation.

Tier III – Systemic Trends
In the past several months BQIS has revamped the Quality Improvement Executive Committee (QIEC) to become more of a decision-making body. Committee members include representatives from all of the entities involved in overseeing waiver services which include:

- •OMPP representative
- •DDRS Director
- •DDRS Deputy Director
- •BQIS and BDDS Directors
- •BDDS Field Service Directors
- •Case Management Liaison
- •Outreach Team Director
- •Crisis Team Liaison
- •BQIS Incident Reporting/Risk Managment Manager
- •BQIS Quality Manager

Committee members independently analyze the data and information reports that their entity routinely produces. In an effort to recognize that no one entity operates independently from the others, entities are encouraged when they identify risk trends to work with each other to develop a mitigation strategy. The QIEC has a worksheet that entities complete describing the opportunity for improvement, the data source, a desired outcome that is measureable, measurement criteria, and a draft mitigation strategy that identifies people responsible and timelines for implementation, and a timeframe to measure how the identified issue changed. If no change or negative change has occurred the plan is to develop another mitigation strategy to attempt to resolve the problem. Meetings are held monthly and time is spent reviewing and finalizing mitigation strategies. All final mitigation strategies are tracked on a shared database so people can check when their assignments are due. The QIEC Coordinator maintains this shared database and also reminds members when they have assignments that are coming due.

BQIS is currently in the process of designing a statewide risk management committee that will include advocate/family/guardian and provider representatives. The purpose of this committee is to review systemic issues identified from all of our data sources and to develop remediation plans. We will need to identify criteria for prioritizing issues that the committee analyzes. One of the goals of having this committee is to generate provider and consumer best practice information that can be revised as necessary to apply to the system.

**ii. System Improvement Activities**

| **Responsible Party** *(check each that applies):* | **Frequency of Monitoring and Analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☐ **Annually** |
| ☐ **Other** | ☐ **Other** |

| Specify: | Specify: |
|---|---|
| | |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

There are many roles and responsibilities that monitor and assess system design changes.

•Providers are responsible for reporting critical incidents through the incident reporting system. Once an incident report is received a series of follow-up activities occur. This system provides the agency with a mechanism to review with the provider the effectiveness of their systems, design changes, etc.

•Case managers have the front-line responsibility for overseeing the delivery of waiver services. They are responsible for making a minimum of 4 contacts with the participant each year, coordinating and facilitating participants' support team meetings as necessary, and identifying and resolving issues with service delivery. Case managers can assess the effectiveness of system and design changes according to how these changes impact the participants they work with.

•BDDS service coordinators oversee state district activities. Service coordinators follow participants, monitor risk plans and follow up with teams to ensure participants are being adequately supported. This system allows the agency to monitor and follow up directly with providers to monitor and provide feedback about their systems, design changes, etc.

•BDDS provider relations works with providers on the front end. To become a provider an applicant must submit all of their provider policies and procedures for BDDS provider relations review. Applicants may also go through an interview process to assure that they meet provider requirements and have the skills necessary to deliver quality services. As we identify issues and how to resolve them we will modify the information that provider relations requests up front.

•BQIS surveyors evaluate the services participants are receiving. Every month survey managers aggregate and analyze transition monitoring results, financial review findings, and results from the comprehensive surveys to evaluate that our systems are operating efficiently. When inefficiencies are identified processes are modified accordingly.

•BQIS incident reviewers review and code all critical incidents reported. They determine when incidents are sentinel and therefore require immediate contact with the provider to assure the individual's safety.

•The QIEC includes representatives from OMPP and all relevant DDRS entities. This committee uses systemic data from all of our monitoring activities to make decisions for how to address risk trends. Mitigation strategies are developed based on analyzed data and measurement criteria are defined with timelines for periodically measuring progress.

•The sanctions committee includes representatives from OMPP, the Division of Aging, and all of DDRS entities. BDDS and BQIS have defined processes for conducting their review activities. Providers are referred to the sanctions committee when all efforts to cooperate have failed.

All of these roles and responsibilities continually evolve as we continue to analyze our data and identify opportunities for improvement. As our new monitoring activities continue to produce more data we will have better information to analyze and support changing our processes to prevent reoccurrence of negative outcomes.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The development of a fully operational quality improvement strategy is an ongoing process of review and refinement.

Some elements of its development are the following specific tasks:

-As more BQIS comprehensive survey, transition monitoring, and financial review data becomes available BQIS will be combining data from these sources. Eventually we will have individual profiles which should help us direct how we use our resources. BQIS produces monthly and quarterly reports with aggregated data and analysis based on findings from each of these monitoring activities.

-Measuring the impact of QIEC mitigation strategies using the identified data sources within the specified timeframes.

-Developing provider report cards that will assist participants in selecting waiver providers by providing information on the provider's performance. The draft template of a provider report card will be developed by 2011. It is anticipated that by that time BQIS will have sufficient data from its monitoring activities to determine how to compile meaningful information.

Modifications to the quality improvement strategy will be submitted annually with the 372 report.

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Indiana State Board of Accounts is responsible for the state's financial audit program. As an agency of the executive branch, the State Board of Accounts audits all governmental units within the state, including cities, towns, utilities, schools, counties, license branches, state agencies, hospitals, libraries, townships, and state colleges and universities. The Indiana State Board of Accounts, as part of the audit process, renders opinions on the fairness of presentation of the various units financial statements in accordance with the same professional auditing standards required of all independent audit organization. Investigatory audits are performed to reveal fraud or noncompliance with local, state and federal statutes. (IC 5-11).

Approximately forty state units receive federal assistance. In addition to compliance with state statutes and regulations, these units are required to comply with specific federal regulations. The State Board of Accounts is required to annually audit the federal programs in compliance with the OMB Circular A-133, Audits of State, Local Governments, and Non-Profit Organizations. The staff at the State Board of Accounts must continually be aware of changing regulations to ensure proper audit coverage.

The State Board of Accounts (SBOA) annually reviews components of the Medicaid program. The SBOA performs an annual A-133 audit of the Medicaid Program. The audit includes testing of generally accepted accounting principles and internal controls pertaining to compliance requirements for Federal Programs.

During the audit period, Medicaid Financial Leaders meet bi-weekly with State Board of Accounts (SBOA) auditors to discuss possible findings. If and when audit findings are issued, the Medicaid agency promptly provides a corrective action plan to SBOA addressing each noted deficiency. On all issued audit findings, testing is performed internally by the Program Integrity Department as well as SBOA to determine if the corrective action plan is properly being applied. Documentation is collected relative to the audit finding and submitted to SBOA for review. On annual basis, Medicaid submits status updates to SBOA regarding implementation of corrective action plans.

This includes OMPP Director of Finance, OMPP Director of Program Integrity, OMPP Director of Federal Funding, OMPP Controller, Agency Controller and SBOA InCharge auditors. CFO periodically attends meetings. Member of FSSA Internal Audit attends regularly as well.

Audit objectives of the A-133 include providing reasonable assurance that the following objectives are achieved:
1. Transactions are properly recorded and accounted for to permit the preparation of reliable financial statements and federal reports
2. Transactions are executed in compliance with laws and regulations of contract or grant agreements that could have a

direct and material effect on a Federal Program
3. Funds, property or other assets are safeguarded against loss
The aforementioned testing includes the validation of financial control objectives such as: authorization, accuracy, completeness, timeliness/cutoff, segregation of duties and existence.
Audit programs are developed outside of the Medicaid Program by audit professionals. The State Board of Accounts (SBOA) performs their audits in compliance with GAAP and GASB standards. SBOA does not report to Medicaid, and therefore, they are deemed to be an independent party.

OMPP is working with the State Board of Accounts to develop DD Waiver testing procedures to provide assurance that audit samples reflect population statistics.

The provider in accordance must maintain for the purposes of the service agreement an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP), as interpreted by the Division of Developmental Disability and Rehabilitative Services (DDRS), and to any other accounting requirements which DDRS may require.

The DDRS or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, DDRS may at any time conduct audits for the purpose of assuring appropriate administration and delivery of services under the service agreement.

The provider must provide DDRS access at any time to all records, materials, and information including all audit reports with supporting documentation. Such access will be provided until the expiration of six years from the completion date of each respective fiscal year.

As noted within Appendix A-3 of this application, the auditing function has been incorporated into the Surveillance Utilization Review (SUR) functions of the contract negotiated between the Medicaid agency and selected contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate possible problems. The Contractor submits recommendations for review based on their data.

Audit findings are triaged based on risk to the Medicaid agency. Each audit finding is assigned a risk level from 1 to 4. Audit findings deemed to be high risk are given priority over lower risk levels. All audits are tracked through a control matrix log monitored by management. It is the goal of the Program Integrity Department to receive audit updates on a quarterly basis from Department Directors.

For the service provider selected for self review, the self review process is thoroughly explained in the audit request letter. Educational seminars are also conducted which include educating providers on the different types of audits that the state performs throughout the year. Please see the link below to the Indiana Health Coverage Programs Provider Manual. Chapter 13 covers Utilization Review.

http://www.indianamedicaid.com/ihcp/Publications/manuals.htm

In the past Indiana set threshold limits on self-audits, desk reviews and on-site audits. This type of business model was ineffective in identifying the most egregious providers. Our focus has moved from threshold auditing to risk based assessments. Audits are performed based on identification of aberrant billing patterns and other risk factors such as the correcting claims. The State of Indiana has formed an Audit Committee as a form of governance over the Program Integrity Department. The Audit Committee consists of cross-functional members representing waivers, care programs, and financial leaders. Prior to the initiation of an on-site audit, detailed case work-ups are evaluated and submitted to the Committee for approval.

On -site audits are approved for providers engaged in consistent inappropriate billing. An On-site review consists of a review of claims and supporting documentation for claims submitted, recoupment of inappropriately paid monies as applicable, educating the provider regarding future claim submission, and if warranted, placing the provider on prepayment review monitoring for future claim submissions. The State works collaboratively with the SUR vendor to develop an audit program which will mitigate risk to the State.

Supportive documentation is obtained for each audit finding annually. The documentation is deemed to be a representative of the population. The evidence is evaluated and compared to the audit finding by Certified Public Accountants. If the evidence is found to be sufficient, Medicaid recommends closure of the audit to State Board of

Accounts along with the evidence. Should audits remain open, an updated status report is compiled and provided to the appropriate parties.

The selected contractor's audit process utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and issues referred by the state. The member's eligibility for waiver services will be validated. On-site visits will be conducted to verify that services billed are authorized in the plan of care, are being delivered, and are meeting the needs of the member. A major focus of the SUR audit exit process is provider education.

Additionally, it is expected that OMPP staff will periodically accompany the contractor on-site, to observe the waiver services.

OMPP exercises oversight and monitoring of the deliverables stipulated within the Surveillance Utilization Review contract in order to ensure the contracting entity satisfactorily performs auditing functions under the conditions of its contract. The OMPP Audit Task force meets biweekly to review and approve the SUR Contractor's recommendations. OMPP oversees the contractor's aggregate data to identify common problems, determine benchmarks and can provide data to providers to compare against aggregate data.

The State's Medicaid Management Information System (MMIS) is used for claims payment submitted by approved waiver providers. The MMIS only reimburses waiver services that have been approved on an appropriate plan of care. Providers submit claims via the MMIS. The electronic case management database system sends authorization for specific units of services to the claims payment system. The claims payment system pays only those claims that meet all authorization requirements. The Indiana Medicaid fiscal intermediary uses system edits and audits to make the appropriate reimbursement for services. When an audit shows a misuse of funds, the State recoups the money from the provider.

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Claims are paid in adherence to reimbursement methodology in the waiver application -**
**Numerator: Total number of DD Waiver claims paid during review period.**
**Denominator: Total number of DD Waiver claims submitted during review period.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**MMIS Claims Data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: Medicaid Fiscal Contractor | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Claims for services are only paid when dates of service are within the date range on the approved service plan. Numerator: Number of claims denied during review period due to dates of service not falling within date range on approved service plan. Denominator: Total number of claims paid during review period**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**MMIS Claims Data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Medicaid Fiscal Contractor | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case managment system and the MMIS, followed by links of the waiver case management system with the MMIS to assure that only properly coded services, that are approved in an individual's plan of care, are authorized for reimbursement to providers who are Medicaid Waiver approved providers.

DDRS receives monthly printouts from the Medicaid MMIS contractor listing claims that have been reimbursed for individual participants. DDRS reviews this information to identify any issues in relationship with expectations for approved plans of care. This may include identifying issues of possible under or over utilization of monthly services for followup. DDRS investigates these issues and may refer them for followup under the Medicaid Surveillance Utilization Review program. Identified problems requiring further resolution are shared with OMPP.

When a need for systems change is identified by the OMPP Operations and Systems Unit or imbedded quality staff, a process is in place to address the issue. The issue is referred to the Change Control Board for action.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The issue is identified. Depending on the magnitude of the issue, it may be resolved directly with the provider or the participant.

If the issue is identified as a systems issue, the OMPP Data Unit is requested to extract pertinent claims data to verify the problem and determine correction needed.

These issues may be identified by a case manager, service provider, or by waiver unit staff. For these individual cases, DDRS waiver unit staff or the Medicaid Fiscal Contractor provider relations staff address the problem to resolution, depending on the root cause. If an individual problem indicates a larger systemic issue, it is referred to the Change Control Board for action.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The current Rate Determination Methods which will remain in effect for this waiver are described below.

The Division of Disability and Rehabilitative Services (DDRS) initiated and implemented a standardized provider reimbursement rate methodology in CY 2009. This methodology requires that providers be reimbursed for actual services delivered, that the rate for each waiver service is discreet and "transparent", and that the rates treat all providers in a "fair and equitable" fashion. While the standardized rate system was implemented in CY 2009, DDRS continues to test, refine, and update various rate assumptions, invoicing tools, and accountability protocols. Explanations of the continuing Rate Development Tasks & Timelines, and the Rate Methodology are as follow:

RATE DEVELOPMENT TASKS & TIMELINES

The provider reimbursement rate initiative currently involves three key tasks. These tasks are: reimbursement rate methodology review and evaluation; rate development and testing; and rate revision and implementation. A description of each task is as follows:

1.Reimbursement Rate Methodology Review and Evaluation: DDRS continues to conduct a review of current provider expenditure and utilization data, reimbursement rate methodologies, assumptions and pricing incentives, budget forecasting and cost containment strategies, risk management and risk reserve practices. This review involves the examination of provider operating expense sheets, annual audited financial reports, and focused discussions with statewide provider organizations.

2.Rate Development and Testing: Initial provider reimbursement rates were published July 2007 and implemented over a twenty-four month period. These rates were based upon the fiscal and service utilization data, provider expenditure data, and program benchmarks based upon DDRS policy. This methodology / standard fee schedule identified critical cost factors and relevant pricing benchmarks. This fee schedule together with the Objective Assessment System for Individual Supports (OASIS) service utilization standards serves as the basis for calibration of the Inventory for Client and Agency Planning (ICAP) to resource allocation levels. Rate testing was initiated in January 2008 and involved only providers in BDDS District 4. Rate testing was expanded statewide to all providers in January 2009.

3.Rate Revision and Implementation: Rate implementation began in January 2008 and became effective statewide in January 2009. Rate revisions will be implemented based upon evaluation and testing findings.

DESCRIPTION OF RATE STRUCTURE

DDRS converted its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for its Medicaid Home and Community-Based Services (HCBS) waiver program. There are three major components to the DDRS Rate Initiative:

Rate Component #1 - Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment / environmental modifications and transportation, all provider reimbursement is based upon the amount of direct care staff time delivered to the participant by the provider. In order to meet the conditions for payment, the participant must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and present to provide the HCBS service. In addition, the service provided must be consistent with the participant's individual service plan.

Rate Component #2 - Standardized Cost Centers: All provider reimbursement rates consist of four cost centers. These cost centers are:

•Direct care Staff Compensation: Two primary job classes were used from these compensation studies. Job classifications used for Personal Support Workers are staff who perform typical duties of a developmental disabilities attendant with a high school degree and no special training. Job classifications used for Habilitation Workers are staff who perform the duties of a developmental disabilities attendant with an Associate Arts degree or Certified Nursing Assistant, or special training.

•Employee Expenses: Employment related expenditures refer to the benefits package that is offered to all employees who are involved in the care and services provided to the person with disabilities and are divided into two groups. Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Non-discretionary costs are those related to employment expenditures that are mandated by local, State, and Federal governments and are not optional to the employer.

•Program Supervision and Indirect Expenses: Program Related Expenditures are those that are part of the operation of the setting in which residential habilitation occurs and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include program management and clinical staff costs as well as program operational expenses.

•General & Administrative Expenses: General and Administrative costs are those associated with operating the organization's business and administration and are not directly related to the clients or the programs that serve the clients.

Rate Component #3 - Other Factors: In addition standardized cost centers have been applied.

• Historical expenditures were used as the basis for transportation rates. The average cost per person was utilized and the transportation rate was applied only to people who were receiving fewer than 35 hours per week of Residential Habilitation and Support each week.

| Service Description | Rate | Unit | Size | Unit/Price Limit |
|---|---|---|---|---|
| Adult Day Service-Level 1 | $21.95 | 0.50 | DAY | 2 Units per Day |
| Adult Day Service-Level 2 | $28.80 | 0.50 | DAY | 2 Units per Day |
| Adult Day Service-Level 3 | $34.29 | 0.50 | DAY | 2 Units per Day |
| Adult Day Service-1/4-hour - | | | | |
| Level 1 | $1.38 | 0.25 | HOUR | 12 Units per Day |
| Level 2 | $1.80 | 0.25 | HOUR | 12 Units per Day |
| Level 3 | $2.14 | 0.25 | HOUR | 12 Units per Day |
| Adult Foster Care - | | | | |
| Level 1- Day | $51.87 | 1.00 | DAY | 1 Unit per Day |
| Level 2- Day | $75.67 | 1.00 | DAY | 1 Unit per Day |
| Level 3- Day | $102.87 | 1.00 | DAY | 1 Unit per Day |
| Behavioral Support - | | | | |
| Level 1 | $18.20 | 0.25 | HOUR | |
| Level 2 | $18.20 | 0.25 | HOUR | |
| Community Habilitation - | | | | |
| Group 2:1 | $13.03 | 1.00 | HOUR | |
| Group 3:1 | $8.96 | 1.00 | HOUR | |
| Group 4:1 | $6.52 | 1.00 | HOUR | |
| Community Habilitation - | | | | |
| Individual | $25.00 | 1.00 | HOUR | |
| Community Transition - | | | | |

-Individual 1.00 UNIT $1,000 Lifetime

Electronic Monitoring $4.54 1.00 HOUR

Environmental Modification-
-Install Individual 1.00 UNIT $15,000 Lifetime
-Maintain Individual 1.00 UNIT $500 per Year
-Equip-Assess/Inspect/Train $17.99 0.25 HOUR

Facility Based Habilitation -
Group 2:1 $14.76 1.00 HOUR
Group 4:1 $ 7.38 1.00 HOUR
Group 6:1 $ 4.92 1.00 HOUR
Group 8:1 $ 3.69 1.00 HOUR
Facility Based Habilitation -
Individual $23.48 1.00 HOUR

Facility Based Support
(max 16:1) $1.85 1.00 HOUR Per Participant Hour

Family & Caregiver Training -
Family Individual 1.00 UNIT $2,000 per Year
Family & Caregiver Training -
Non-Family Individual 1.00 UNIT $2,000 per Year

Intensive Behavioral Intervention -
Level 1 $104.6 1.00 HOUR Per Lvl-1 Staff Hour
Level 2 $25.00 1.00 HOUR Per Lvl-2 Staff Hour

Music Therapy $10.78 0.25 HOUR

Occupational Therapy $17.99 0.25 HOUR

Personal Response System -
Install $52.07 1.00 UNIT 2 Units per CCB
Personal Response System -
Maintain $52.07 1.00 MONTH 1 Unit per Month

Physical Therapy $18.12 0.25 HOUR

Pre - Vocational -
Group 8:1 $6.00 1.00 HOUR
Group 10:1 $4.80 1.00 HOUR
Group 12:1 $4.00 1.00 HOUR
Group 14:1 $3.42 1.00 HOUR
Group 16:1 $3.00 1.00 HOUR

Psychological Therapy-Family $17.27 0.25 HOUR
Psychological Therapy-Group $4.81 0.25 HOUR
Psychological Therapy-Individual $15.45 0.25 HOUR

Recreational Therapy $10.78 0.25 HOUR

Rent & Food for Unrelated Live-in Caregiver
$545.00 1.00 MONTH
Residential Habilitation Services -
35 hrs or less/week $25.00 1.00 HOUR
Residential Habilitation Services -
Over 35 hrs/week $21.00 1.00 HOUR

Respite Nursing Care (RN) $7.79 0.25 HOUR
Respite Nursing Care (LPN) $5.91 0.25 HOUR

Respite Services $25.00 1.00 HOUR

Specialized Med Equip/Supply -
Install Individual 1.00 UNIT
Specialized Med Equip/Supply –
Maintain Individual 1.00 UNIT $500 per Year

Speech Therapy $18.12 0.25 HOUR

Supported Employment -
Tier 1 (Monthly 1-5 hours) $175.95 1.00 MONTH
Tier 2 (Monthly 6-10 hours) $351.90 1.00 MONTH
Tier 3 (Monthly 11-15 hours)$527.85 1.00 MONTH
Tier 4 (Hourly) $35.19 1.00 HOUR

Transportation $4.80 1.00 TRIP 2 Trips per Day

Vehicle Modification -
Install Individual 1.00 UNIT $20,000 Lifetime
Vehicle Modification
Maintenance Individual 1.00 UNIT $500 per Year

Workplace Assistance $26.37 1.00 HOUR

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

- ◉ **No. State or local government agencies do not certify expenditures for waiver services.**
- ○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State

verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a)and b)

As outlined under Appendix D, the service plan development process encompasses the use of reimbursable as well as non-paid services and supports, including natural supports when available. The Case Manager is responsible for incorporating into the participant's Individualized Support Plan (ISP), the entire array of services and supports necessary to meet the needs of the participant.
However, the Plan of Care/Cost Comparison Budget (POC/CCB) associated with the DD Waiver contains only those reimbursable services from the ISP that are available under the DD Waiver.

The Division of Disability and Rehabilitative Services' (DDRS) Waiver Services Unit approves a participant's POC/CCB within the State's case management application database ensuring that only those services which are necessary and reimbursable under the DD Waiver appear on the POC/CCB when prior authorization is sent to the state's MMIS. The case management data system will not allow the addition of services beyond those services offered under the DD Waiver. The case management data system has been programmed to alert the Waiver Unit when a POC/CCB is being reviewed for a participant whose Medicaid eligibility status is not currently open within an acceptable category as was discussed under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the Approval of the POC/CCB generates a Notice of Action (NOA) which is sent to each authorized provider of services on the Plan. The NOA identifies the individual service recipient (the participant), the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management data base transmits a data package (typically each business night) containing all new or modified POC/CCB service and rate information to the Indiana MMIS. The POC/CCB data is utilized by the MMIS as the basis to create or modify Prior Authorizations for billing of services against Medicaid waiver participants.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made according the Prior Authorization remaining for the claimed unit(s) during the dates of service being claimed against. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

c) Documentation and proof of actual service delivery tied to the billing by the provider agency will be reviewed during the look behind efforts of the Bureau of Quality Improvement Services as well as by the contractor selected to fill the Surveillance Utilization Review (SUR) contract executed by the Office of Medicaid Policy and Planning.

In summary, the participant's eligibility for Medicaid and eligibility for approved dates of service are controlled through the electronic case management database system which is linked to Medicaid's claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with participant the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

## Appendix I: Financial Accountability

**I-3: Payment** (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct**

**payments to a governmental agency.**

- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

  Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

  Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

*Check each that applies:*

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

**I-4: Non-Federal Matching Funds** (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver except for the provision of Rent and Food for Unrelated Live-In Caregiver. No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified/approved. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Note: The waiver does not provide services in group home settings. Waiver particpants are responsible for all room and board costs.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- ( ) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver**

**who resides in the same household as the participant.**

- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

a) The State uses the following method to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

•Room and board expenses of non-related, live-in caregivers are based on an estimate of the cost of food and housing in typical two and three bedroom apartments. The amount paid for live-in caregiver will be up to the federal benefit level under SSI for an individual living in the home of another, or actual expenses, whichever is the lesser amount

b) This service must be an approved service and included in the Plan of Care/Cost Comparison Budget (POC/CCB) in order to be reimbursed through the Medicaid MMIS.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the

Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: ICF/MR**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 74409.06 | 6385.00 | 80794.06 | 79657.00 | 4481.00 | 84138.00 | 3343.94 |
| 2 | 76330.89 | 6768.00 | 83098.89 | 82843.00 | 4749.00 | 87592.00 | 4493.11 |
| 3 | 78994.03 | 7174.00 | 86168.03 | 86157.00 | 5034.00 | 91191.00 | 5022.97 |
| 4 | 81544.48 | 7604.00 | 89148.48 | 89603.00 | 5336.00 | 94939.00 | 5790.52 |
| 5 | 84609.13 | 8061.00 | 92670.13 | 93187.00 | 5657.00 | 98844.00 | 6173.87 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Number Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | ICF/MR |
| Year 1 | 7370 | 7370 |
| Year 2 | 7637 | 7637 |
| Year 3 | 7896 | 7896 |
| Year 4 | 8148 | 8148 |
| Year 5 | 8388 | 8388 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Phase-in/Phase-out charts were completed for each waiver year.

Indiana is requesting slots that will allow it to add approximately 42 consumers each month. Approximately half of these are expected to be selected based on priority criteria, while half will be selected based on waitlist status.

From historical experience, the expected lapse rate for this population is approximately 0.28% per month. The number of lapses is expected to grow with total waiver slots over the five year renewal period, from a current level of 19 lapses per month to approximately 23 lapses per month at the end of Waiver Year 5.

## Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates** (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

For most services, Factor D is derived from incurred experience for the current Waiver Year 4: October 1, 2007 – September 30, 2008. Exceptions were made both for new services and services which have recently been restructured. Methodology for these services are provided at the end of this section.

The number of users of each service was taken from incurred experience for the current Waiver Year 4: October 1, 2007 – September 30, 2008. Data from this period was adjusted to reflect expected changes in the total number of unduplicated participants during each waiver year.

The average units per user was similarly taken from incurred experience for the current Waiver Year 4: October 1, 2007 – September 30, 2008. This was adjusted each waiver year for changes in the average length of stay on waiver.

Average cost per unit: current rates were used for the filed Waiver Year 1. Rates for subsequent waiver years were developed using an annual trend rate of 3.5%.

Restructured services:
Day Services has been split into Community Based Habilitation, Facility Based Habilitation, Pre-Vocational Services, and Supported Employment Follow Along. In addition, Residential Habilitation and Behavior Management have been converted from monthly units to one hour and quarter hour units respectively. Approximately 10% of waiver recipients have been participating in a pilot program including the restructured services since April 2008. Transition for the remainder of waiver recipients began in January 2009. Utilization patterns for the pilot group and from those transitioned early in 2009 has been extrapolated to the full waiver population for purposes of this waiver filing. The unbundling process will be complete for all participants by the beginning of the waiver renewal period on October 1, 2009.

To recognize new time limitations to be placed on utilization of Pre-Vocational Services and Supported Employment (12 months and 18 months respectively), the level of unduplicated users of these services has been reduced to be consistent with the current annual number of new users of this service, as a percentage of total waiver enrollment.

New Services:
•Electronic Monitoring Services: Utilization patterns of the State Line service by those currently eligible were extrapolated to the full waiver population.
•Facility Based Support: DDRS has estimated that 40% of DDW consumers will use this service, in many cases as a substitution for Pre-Vocational or Facility Based Habilitation services.
•Intense Behavioral Intervention: DDRS assumes 3% of DDW consumers will use this service, mainly children. Utilization of level 2 IBI replaces utilization of Residential Habilitation.
•Transportation: All eligible DDW consumers are assumed to use one round trip (two trips) each weekday.
•Workplace Personal Assistance: Assumed to be used by all DDW consumers with paid employment.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from incurred experience for the current Waiver Year 4: October 1, 2007 – September 30, 2008. This factor was trended at a rate of 8% for one year (to the current Waiver Year 5) in order to take into account a one-time 17% rate increase for Home Health Services. For all other future years, this factor was inflated at a rate of 6% per year.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Over the last ten years, Indiana has closed the majority of its State ICF/MR Facilities. As of the end of SFY 1997, there were approximately 1,200 residents of State Facilities. At the present time, there are only 107 residents of State Facilities. To accommodate displaced residents of State Facilities, Indiana has opened small

group homes with special support, Extensive Support Needs (ESN) Group Homes and Medically Fragile Group Homes (MFGH). Combined, these new homes serve an additional 150 residents in smaller facilities. The remainder of displaced State Facility residents are being served in the community.

The State facilities have traditionally served patients with the most intensive needs. As of the beginning of Waiver Year 4 (October 1, 2007), there were over 800 DD Waiver participants (13.8%) who had transitioned from State Facilities. As a group, these individuals utilize a significantly higher level of waiver services than other waiver participants.

To recognize the large number of waiver participants with intense needs, the Developmentally Disabled Waiver population was divided into two groups: those who had transitioned from State Facilities (Transitions) and those who were diverted from entering an ICF/MR facility through access to waiver services (Diversions).

Factor G for the Transition Group was developed by trending the historical Factor G from the closed State facility from which each participant had transitioned. Each Factor G selected was from a base time period that reflected the cost of care when the facility was at full capacity (i.e. prior to the impact of downsizing and closing the facility). Each Factor G was trended by 4% per year to the current Waiver Year 4 period : October 1, 2007 – September 30, 2008.

Factor G for the Diversion Group is derived from incurred experience from the current Waiver Year 4 period: October 1, 2007 – September 30, 2008 for institutional residents of non-State, ICF/MR Facilities. Costs for ESN and MFGH facilities were also excluded as this Factor G is intended to represent the cost of care for less complex ICF/MR residents.

A composite Factor G was developed as a weighted average (by waiver enrollment) of Factor G for the Transition Group and Factor G for the Diversion Group.

This factor was inflated at a rate of 4% each year.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from incurred experience from the current Waiver Year 4 period: October 1, 2007 – September 30, 2008 for institutional residents of ICF/MR Facilities. This factor was inflated at a rate of 6% each year.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services |
|---|
| **Adult Day Services** |
| **Prevocational Services** |
| **Rent and Food for Unrelated Live-in Caregiver** |
| **Residential Habilitation and Support** |
| **Respite** |
| **Supported Employment Follow Along** |
| **Occupational Therapy** |
| **Physical Therapy** |
| **Psychological Therapy** |
| **Speech /Language Therapy** |
| **Adult Foster Care** |

| |
|---|
| **Behavioral Support Services** |
| **Community Based Habilitation - Group** |
| **Community Based Habilitation - Individual** |
| **Community Transition** |
| **Electronic Monitoring** |
| **Environmental Modifications** |
| **Facility Based Habilitation - Group** |
| **Facility Based Habilitation - Individual** |
| **Facility Based Support Services** |
| **Family and Caregiver Training** |
| **Intensive Behavior Intervention** |
| **Music Therapy** |
| **Personal Emergency Response System** |
| **Recreational Therapy** |
| **Specialized Medical Equipment and Supplies** |
| **Transportation** |
| **Workplace Assistance** |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Services Total:** | | | | | | **1098609.17** |
| Adult Day Service - half day - Level 1 | half day | 24 | 191.00 | 22.72 | **104148.48** | |
| Adult Day Service - half day - Level 2 | half day | 49 | 251.00 | 29.81 | **366633.19** | |
| Adult Day Service - half day - Level 3 | half day | 77 | 226.00 | 35.49 | **617596.98** | |
| Adult Day Service - 1/4 hour - Level 1 | 1/4 hour | 1 | 2123.00 | 1.43 | **3035.89** | |
| Adult Day Service - 1/4 hour - Level 2 | 1/4 hour | 1 | 1405.00 | 1.86 | **2613.30** | |
| Adult Day Service - 1/4 hour - Level 3 | 1/4 hour | 1 | 2073.00 | 2.21 | **4581.33** | |
| **Prevocational Services Total:** | | | | | | **5009555.52** |
| Prevocational Services (8:1) | hour | 423 | 749.00 | 6.21 | **1967495.67** | |
| Prevocational Services (10:1) | hour | 355 | 495.00 | 4.97 | **873353.25** | |
| Prevocational Services (12:1) | hour | 425 | 807.00 | 4.14 | **1419916.50** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Prevocational Services (14:1) | hour | 213 | 441.00 | 3.54 | **332522.82** | |
| Prevocational Services (16:1) | hour | 234 | 572.00 | 3.11 | **416267.28** | |
| **Rent and Food for Unrelated Live-in Caregiver Total:** | | | | | | **20253.60** |
| Rent and Food for Unrelated Live-in Caregiver | month | 3 | 12.00 | 562.60 | **20253.60** | |
| **Residential Habilitation and Support Total:** | | | | | | **454350609.42** |
| Residential Habilitation and Support - 35 hours or less/week | hour | 2110 | 1019.00 | 24.51 | **52698705.90** | |
| Residential Habilitation and Support - Over 35 hours/week | hour | 4692 | 4242.00 | 20.18 | **401651903.52** | |
| **Respite Total:** | | | | | | **3746069.24** |
| Respite Nursing Care (RN) | 1/4 hour | 7 | 946.00 | 8.06 | **53373.32** | |
| Respite Nursing Care (LPN) | 1/4 hour | 22 | 693.00 | 6.12 | **93305.52** | |
| Respite | hour | 760 | 183.00 | 25.88 | **3599390.40** | |
| **Supported Employment Follow Along Total:** | | | | | | **5344456.59** |
| Supported Employment Follow Along - Tier 1 | month | 489 | 11.00 | 182.11 | **979569.69** | |
| Supported Employment Follow Along - Tier 2 | month | 433 | 11.00 | 364.22 | **1734779.86** | |
| Supported Employment Follow Along - Tier 3 | month | 167 | 11.00 | 546.32 | **1003589.84** | |
| Supported Employment Follow Along - Tier 4 | hour | 203 | 220.00 | 36.42 | **1626517.20** | |
| **Occupational Therapy Total:** | | | | | | **24415.60** |
| Occupational Therapy | 1/4 hour | 4 | 341.00 | 17.90 | **24415.60** | |
| **Physical Therapy Total:** | | | | | | **1725.00** |
| Physical Therapy | 1/4 hour | 1 | 92.00 | 18.75 | **1725.00** | |
| **Psychological Therapy Total:** | | | | | | **2539.44** |
| Psychological Therapy - Family | 1/4 hour | 0 | 0.00 | 0.01 | **0.00** | |
| Psychological Therapy - Individual | 1/4 hour | 13 | 8.00 | 15.99 | **1662.96** | |
| Psychological Therapy - Group | 1/4 hour | 44 | 4.00 | 4.98 | **876.48** | |
| **Speech /Language Therapy Total:** | | | | | | **19275.00** |
| Speech /Language Therapy | 1/4 hour | 4 | 257.00 | 18.75 | **19275.00** | |
| **Adult Foster Care Total:** | | | | | | **7821160.92** |
| Adult Foster Care Level 1 | day | 63 | 349.00 | 53.69 | **1180482.03** | |
| Adult Foster Care Level 2 | day | 162 | 341.00 | 78.32 | **4326553.44** | |
| Adult Foster Care Level 3 | day | 63 | 345.00 | 106.47 | **2314125.45** | |
| **Behavioral Support Services Total:** | | | | | | **17349813.76** |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Behavior Support Services - Level 1 | 1/4 hour | 3961 | 8.00 | 18.56 | **588129.28** | |
| Behavior Support Services - Level 2 | 1/4 hour | 3961 | 228.00 | 18.56 | **16761684.48** | |
| **Community Based Habilitation - Group Total:** | | | | | | **3985260.35** |
| Community Based Habilitation - Group - (2:1) | hour | 436 | 85.00 | 13.49 | **499939.40** | |
| Community Based Habilitation - Group - (3:1) | hour | 480 | 86.00 | 8.99 | **371107.20** | |
| Community Based Habilitation - Group - (4:1) | hour | 1741 | 265.00 | 6.75 | **3114213.75** | |
| **Community Based Habilitation - Individual Total:** | | | | | | **7265300.00** |
| Community Based Habilitation - Individual | hour | 1498 | 194.00 | 25.00 | **7265300.00** | |
| **Community Transition Total:** | | | | | | **135506.34** |
| Community Transition | unit | 138 | 1.00 | 981.93 | **135506.34** | |
| **Electronic Monitoring Total:** | | | | | | **1856727.60** |
| Electronic Monitoring | hour | 147 | 2776.00 | 4.55 | **1856727.60** | |
| **Environmental Modifications Total:** | | | | | | **448208.11** |
| Environmental Modifications - Install/Maintain | unit | 63 | 1.00 | 7112.13 | **448064.19** | |
| Environmental Modifications - Equipment/Assessment/Inspection | unit | 1 | 8.00 | 17.99 | **143.92** | |
| **Facility Based Habilitation - Group Total:** | | | | | | **4153771.42** |
| Facility Based Habilitation - Group (2:1) | hour | 385 | 332.00 | 15.28 | **1953089.60** | |
| Facility Based Habilitation - Group (4:1) | hour | 630 | 203.00 | 7.64 | **977079.60** | |
| Facility Based Habilitation - Group (6:1) | hour | 683 | 193.00 | 5.10 | **672276.90** | |
| Facility Based Habilitation - Group ( 8:1) | hour | 793 | 182.00 | 3.82 | **551325.32** | |
| **Facility Based Habilitation - Individual Total:** | | | | | | **2091175.00** |
| Facility Based Habilitation - Individual | hour | 233 | 359.00 | 25.00 | **2091175.00** | |
| **Facility Based Support Services Total:** | | | | | | **5322451.85** |
| Facility Based Support Services | hour | 2909 | 989.00 | 1.85 | **5322451.85** | |
| **Family and Caregiver Training Total:** | | | | | | **26641.72** |
| Family and Caregiver Training | unit | 17 | 4.00 | 391.79 | **26641.72** | |
| **Intensive Behavior Intervention Total:** | | | | | | **5418329.93** |
| Intensive Behavior Intervention - Level 1 | hour | 221 | 57.00 | 104.69 | **1318779.93** | |
| Intensive Behavior Intervention - Level 2 direct care staff | hour | 221 | 742.00 | 25.00 | **4099550.00** | |
| **Music Therapy Total:** | | | | | | **729329.58** |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Music Therapy | 1/4 hour | 431 | 153.00 | 11.06 | **729329.58** | |
| **Personal Emergency Response System Total:** | | | | | | **72906.75** |
| Personal Emergency Response System | unit/month | 175 | 9.00 | 46.29 | **72906.75** | |
| **Recreational Therapy Total:** | | | | | | **247086.45** |
| Recreational Therapy | 1/4 hour | 117 | 195.00 | 10.83 | **247086.45** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **62443.29** |
| Specialized Medical Equipment and Supplies | unit | 21 | 1.00 | 2973.49 | **62443.29** | |
| **Transportation Total:** | | | | | | **4863711.58** |
| Transportation | trip | 1981 | 494.00 | 4.97 | **4863711.58** | |
| **Workplace Assistance Total:** | | | | | | **16927430.40** |
| Workplace Assistance | hour | 590 | 1088.00 | 26.37 | **16927430.40** | |
| | | | | **GRAND TOTAL:** | | **548394763.63** |
| | | | | **Total Estimated Unduplicated Participants:** | | **7370** |
| | | | | **Factor D (Divide total by number of participants):** | | **74409.06** |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (6 of 9)

### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Services Total:** | | | | | | **1171189.44** |
| Adult Day Service - half day - Level 1 | half day | 24 | 191.00 | 23.51 | **107769.84** | |
| Adult Day Service - half day - Level 2 | half day | 50 | 252.00 | 30.85 | **388710.00** | |
| Adult Day Service - half day - Level 3 | half day | 80 | 226.00 | 36.73 | **664078.40** | |
| Adult Day Service - 1/4 hour - Level 1 | 1/4 hour | 1 | 2129.00 | 1.48 | **3150.92** | |
| Adult Day Service - 1/4 hour - Level 2 | 1/4 hour | 1 | 1409.00 | 1.93 | **2719.37** | |
| Adult Day Service - 1/4 hour - Level 3 | 1/4 hour | 1 | 2079.00 | 2.29 | **4760.91** | |
| **Prevocational Services Total:** | | | | | | **1664808.19** |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Prevocational Services (8:1) | hour | 137 | 751.00 | 6.43 | **661563.41** | |
| Prevocational Services (10:1) | hour | 115 | 497.00 | 5.14 | **293776.70** | |
| Prevocational Services (12:1) | hour | 138 | 809.00 | 4.28 | **477827.76** | |
| Prevocational Services (14:1) | hour | 69 | 443.00 | 3.66 | **111875.22** | |
| Prevocational Services (16:1) | hour | 65 | 574.00 | 3.21 | **119765.10** | |
| **Rent and Food for Unrelated Live-in Caregiver Total:** | | | | | | **20962.44** |
| Rent and Food for Unrelated Live-in Caregiver | month | 3 | 12.00 | 582.29 | **20962.44** | |
| **Residential Habilitation and Support Total:** | | | | | | **488824924.02** |
| Residential Habilitation and Support - 35 hours or less/week | hour | 2186 | 1022.00 | 25.36 | **56656573.12** | |
| Residential Habilitation and Support - Over 35 hours/week | hour | 4862 | 4255.00 | 20.89 | **432168350.90** | |
| **Respite Total:** | | | | | | **4034487.53** |
| Respite Nursing Care (RN) | 1/4 hour | 7 | 948.00 | 8.34 | **55344.24** | |
| Respite Nursing Care (LPN) | 1/4 hour | 23 | 695.00 | 6.33 | **101185.05** | |
| Respite | hour | 787 | 184.00 | 26.78 | **3877958.24** | |
| **Supported Employment Follow Along Total:** | | | | | | **2420886.13** |
| Supported Employment Follow Along - Tier 1 | month | 213 | 11.00 | 188.48 | **441608.64** | |
| Supported Employment Follow Along - Tier 2 | month | 189 | 11.00 | 376.96 | **783699.84** | |
| Supported Employment Follow Along - Tier 3 | month | 73 | 11.00 | 565.45 | **454056.35** | |
| Supported Employment Follow Along - Tier 4 | hour | 89 | 221.00 | 37.70 | **741521.30** | |
| **Occupational Therapy Total:** | | | | | | **31686.30** |
| Occupational Therapy | 1/4 hour | 5 | 342.00 | 18.53 | **31686.30** | |
| **Physical Therapy Total:** | | | | | | **1785.72** |
| Physical Therapy | 1/4 hour | 1 | 92.00 | 19.41 | **1785.72** | |
| **Psychological Therapy Total:** | | | | | | **2801.20** |
| Psychological Therapy - Family | 1/4 hour | 0 | 0.00 | 0.01 | **0.00** | |
| Psychological Therapy - Individual | 1/4 hour | 14 | 8.00 | 16.55 | **1853.60** | |
| Psychological Therapy - Group | 1/4 hour | 46 | 4.00 | 5.15 | **947.60** | |
| **Speech /Language Therapy Total:** | | | | | | **24941.85** |
| Speech /Language Therapy | 1/4 hour | 5 | 257.00 | 19.41 | **24941.85** | |
| **Adult Foster Care Total:** | | | | | | **8399771.36** |
| Adult Foster Care Level 1 | day | 65 | 350.00 | 55.56 | **1263990.00** | |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Adult Foster Care Level 2 | day | 168 | 342.00 | 81.06 | **4657383.36** | |
| Adult Foster Care Level 3 | day | 65 | 346.00 | 110.20 | **2478398.00** | |
| **Behavioral Support Services Total:** | | | | | | **18684568.08** |
| Behavior Support Services - Level 1 | 1/4 hour | 4104 | 8.00 | 19.21 | **630702.72** | |
| Behavior Support Services - Level 2 | 1/4 hour | 4104 | 229.00 | 19.21 | **18053865.36** | |
| **Community Based Habilitation - Group Total:** | | | | | | **4289158.98** |
| Community Based Habilitation - Group - (2:1) | hour | 452 | 85.00 | 13.96 | **536343.20** | |
| Community Based Habilitation - Group - (3:1) | hour | 498 | 87.00 | 9.31 | **403365.06** | |
| Community Based Habilitation - Group - (4:1) | hour | 1804 | 266.00 | 6.98 | **3349450.72** | |
| **Community Based Habilitation - Individual Total:** | | | | | | **7837369.80** |
| Community Based Habilitation - Individual | hour | 1553 | 195.00 | 25.88 | **7837369.80** | |
| **Community Transition Total:** | | | | | | **145330.90** |
| Community Transition | unit | 143 | 1.00 | 1016.30 | **145330.90** | |
| **Electronic Monitoring Total:** | | | | | | **2006233.92** |
| Electronic Monitoring | hour | 153 | 2784.00 | 4.71 | **2006233.92** | |
| **Environmental Modifications Total:** | | | | | | **485978.26** |
| Environmental Modifications - Install/Maintain | unit | 66 | 1.00 | 7361.05 | **485829.30** | |
| Environmental Modifications - Equipment/Assessment/Inspection | unit | 1 | 8.00 | 18.62 | **148.96** | |
| **Facility Based Habilitation - Group Total:** | | | | | | **4464789.30** |
| Facility Based Habilitation - Group (2:1) | hour | 399 | 332.00 | 15.81 | **2094319.08** | |
| Facility Based Habilitation - Group (4:1) | hour | 652 | 204.00 | 7.91 | **1052093.28** | |
| Facility Based Habilitation - Group (6:1) | hour | 707 | 194.00 | 5.28 | **724194.24** | |
| Facility Based Habilitation - Group ( 8:1) | hour | 822 | 183.00 | 3.95 | **594182.70** | |
| **Facility Based Habilitation - Individual Total:** | | | | | | **2245348.80** |
| Facility Based Habilitation - Individual | hour | 241 | 360.00 | 25.88 | **2245348.80** | |
| **Facility Based Support Services Total:** | | | | | | **5712580.80** |
| Facility Based Support Services | hour | 3015 | 992.00 | 1.91 | **5712580.80** | |
| **Family and Caregiver Training Total:** | | | | | | **27574.00** |
| Family and Caregiver Training | unit | 17 | 4.00 | 405.50 | **27574.00** | |
| **Intensive Behavior Intervention Total:** | | | | | | **5823623.43** |
| Intensive Behavior Intervention - Level 1 | hour | 229 | 57.00 | 108.35 | **1414292.55** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Intensive Behavior Intervention - Level 2 direct care staff | hour | 229 | 744.00 | 25.88 | 4409330.88 | |
| **Music Therapy Total:** | | | | | | **781325.10** |
| Music Therapy | 1/4 hour | 446 | 153.00 | 11.45 | 781325.10 | |
| **Personal Emergency Response System Total:** | | | | | | **78045.39** |
| Personal Emergency Response System | unit/month | 181 | 9.00 | 47.91 | 78045.39 | |
| **Recreational Therapy Total:** | | | | | | **265619.20** |
| Recreational Therapy | 1/4 hour | 121 | 196.00 | 11.20 | 265619.20 | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **67706.54** |
| Specialized Medical Equipment and Supplies | unit | 22 | 1.00 | 3077.57 | 67706.54 | |
| **Transportation Total:** | | | | | | **5234000.32** |
| Transportation | trip | 2053 | 496.00 | 5.14 | 5234000.32 | |
| **Workplace Assistance Total:** | | | | | | **18191541.29** |
| Workplace Assistance | hour | 611 | 1091.00 | 27.29 | 18191541.29 | |
| | | | | **GRAND TOTAL:** | | **582939038.29** |
| | | | | **Total Estimated Unduplicated Participants:** | | **7637** |
| | | | | **Factor D (Divide total by number of participants):** | | **76330.89** |
| | | | | **Average Length of Stay on the Waiver:** | | 348 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (7 of 9)

### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Services Total:** | | | | | | **1264271.90** |
| Adult Day Service - half day - Level 1 | half day | 25 | 192.00 | 24.34 | 116832.00 | |
| Adult Day Service - half day - Level 2 | half day | 52 | 253.00 | 31.93 | 420071.08 | |
| Adult Day Service - half day - Level 3 | half day | 83 | 227.00 | 38.02 | 716334.82 | |
| Adult Day Service - 1/4 hour - Level 1 | 1/4 hour | 1 | 2135.00 | 1.53 | 3266.55 | |
| Adult Day Service - 1/4 hour - Level 2 | 1/4 hour | 1 | 1413.00 | 2.00 | 2826.00 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Adult Day Service - 1/4 hour - Level 3 | 1/4 hour | 1 | 2085.00 | 2.37 | **4941.45** | |
| **Prevocational Services Total:** | | | | | | **1784263.61** |
| Prevocational Services (8:1) | hour | 142 | 753.00 | 6.65 | **711057.90** | |
| Prevocational Services (10:1) | hour | 119 | 498.00 | 5.32 | **315273.84** | |
| Prevocational Services (12:1) | hour | 142 | 811.00 | 4.43 | **510167.66** | |
| Prevocational Services (14:1) | hour | 71 | 444.00 | 3.79 | **119475.96** | |
| Prevocational Services (16:1) | hour | 67 | 575.00 | 3.33 | **128288.25** | |
| **Rent and Food for Unrelated Live-in Caregiver Total:** | | | | | | **28928.16** |
| Rent and Food for Unrelated Live-in Caregiver | month | 4 | 12.00 | 602.67 | **28928.16** | |
| **Residential Habilitation and Support Total:** | | | | | | **524588549.83** |
| Residential Habilitation and Support - 35 hours or less/week | hour | 2261 | 1025.00 | 26.25 | **60835031.25** | |
| Residential Habilitation and Support - Over 35 hours/week | hour | 5027 | 4267.00 | 21.62 | **463753518.58** | |
| **Respite Total:** | | | | | | **4318875.60** |
| Respite Nursing Care (RN) | 1/4 hour | 7 | 951.00 | 8.64 | **57516.48** | |
| Respite Nursing Care (LPN) | 1/4 hour | 24 | 697.00 | 6.55 | **109568.40** | |
| Respite | hour | 814 | 184.00 | 27.72 | **4151790.72** | |
| **Supported Employment Follow Along Total:** | | | | | | **701529.88** |
| Supported Employment Follow Along - Tier 1 | month | 60 | 11.00 | 195.08 | **128752.80** | |
| Supported Employment Follow Along - Tier 2 | month | 53 | 11.00 | 390.16 | **227463.28** | |
| Supported Employment Follow Along - Tier 3 | month | 20 | 11.00 | 585.24 | **128752.80** | |
| Supported Employment Follow Along - Tier 4 | hour | 25 | 222.00 | 39.02 | **216561.00** | |
| **Occupational Therapy Total:** | | | | | | **32893.70** |
| Occupational Therapy | 1/4 hour | 5 | 343.00 | 19.18 | **32893.70** | |
| **Physical Therapy Total:** | | | | | | **1848.28** |
| Physical Therapy | 1/4 hour | 1 | 92.00 | 20.09 | **1848.28** | |
| **Psychological Therapy Total:** | | | | | | **2941.92** |
| Psychological Therapy - Family | 1/4 hour | 0 | 0.00 | 0.01 | **0.00** | |
| Psychological Therapy - Individual | 1/4 hour | 14 | 8.00 | 17.13 | **1918.56** | |
| Psychological Therapy - Group | 1/4 hour | 48 | 4.00 | 5.33 | **1023.36** | |
| **Speech /Language Therapy Total:** | | | | | | **25916.10** |
| Speech /Language Therapy | 1/4 hour | 5 | 258.00 | 20.09 | **25916.10** | |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Adult Foster Care Total:** | | | | | | **9071092.28** |
| Adult Foster Care Level 1 | day | 68 | 351.00 | 57.51 | **1372648.68** | |
| Adult Foster Care Level 2 | day | 174 | 343.00 | 83.90 | **5007319.80** | |
| Adult Foster Care Level 3 | day | 68 | 347.00 | 114.05 | **2691123.80** | |
| **Behavioral Support Services Total:** | | | | | | **20075499.92** |
| Behavior Support Services - Level 1 | 1/4 hour | 4243 | 8.00 | 19.88 | **674806.72** | |
| Behavior Support Services - Level 2 | 1/4 hour | 4243 | 230.00 | 19.88 | **19400693.20** | |
| **Community Based Habilitation - Group Total:** | | | | | | **4606507.80** |
| Community Based Habilitation - Group - (2:1) | hour | 468 | 85.00 | 14.45 | **574821.00** | |
| Community Based Habilitation - Group - (3:1) | hour | 515 | 87.00 | 9.63 | **431472.15** | |
| Community Based Habilitation - Group - (4:1) | hour | 1865 | 267.00 | 7.23 | **3600214.65** | |
| **Community Based Habilitation - Individual Total:** | | | | | | **8381470.50** |
| Community Based Habilitation - Individual | hour | 1605 | 195.00 | 26.78 | **8381470.50** | |
| **Community Transition Total:** | | | | | | **155676.76** |
| Community Transition | unit | 148 | 1.00 | 1051.87 | **155676.76** | |
| **Electronic Monitoring Total:** | | | | | | **2148332.32** |
| Electronic Monitoring | hour | 158 | 2792.00 | 4.87 | **2148332.32** | |
| **Environmental Modifications Total:** | | | | | | **518225.08** |
| Environmental Modifications - Install/Maintain | unit | 68 | 1.00 | 7618.69 | **518070.92** | |
| Environmental Modifications - Equipment/Assessment/Inspection | unit | 1 | 8.00 | 19.27 | **154.16** | |
| **Facility Based Habilitation - Group Total:** | | | | | | **4779747.78** |
| Facility Based Habilitation - Group (2:1) | hour | 412 | 333.00 | 16.36 | **2244526.56** | |
| Facility Based Habilitation - Group (4:1) | hour | 674 | 204.00 | 8.18 | **1124717.28** | |
| Facility Based Habilitation - Group (6:1) | hour | 731 | 194.00 | 5.46 | **774304.44** | |
| Facility Based Habilitation - Group ( 8:1) | hour | 850 | 183.00 | 4.09 | **636199.50** | |
| **Facility Based Habilitation - Individual Total:** | | | | | | **2416895.00** |
| Facility Based Habilitation - Individual | hour | 250 | 361.00 | 26.78 | **2416895.00** | |
| **Facility Based Support Services Total:** | | | | | | **6134630.04** |
| Facility Based Support Services | hour | 3117 | 994.00 | 1.98 | **6134630.04** | |
| **Family and Caregiver Training Total:** | | | | | | **30217.68** |
| Family and Caregiver Training | unit | 18 | 4.00 | 419.69 | **30217.68** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Intensive Behavior Intervention Total:** | | | | | | **6249791.91** |
| Intensive Behavior Intervention - Level 1 | hour | 237 | 57.00 | 112.15 | **1515034.35** | |
| Intensive Behavior Intervention - Level 2 direct care staff | hour | 237 | 746.00 | 26.78 | **4734757.56** | |
| **Music Therapy Total:** | | | | | | **835816.05** |
| Music Therapy | 1/4 hour | 461 | 153.00 | 11.85 | **835816.05** | |
| **Personal Emergency Response System Total:** | | | | | | **83459.97** |
| Personal Emergency Response System | unit/month | 187 | 9.00 | 49.59 | **83459.97** | |
| **Recreational Therapy Total:** | | | | | | **286473.60** |
| Recreational Therapy | 1/4 hour | 126 | 196.00 | 11.60 | **286473.60** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **70076.16** |
| Specialized Medical Equipment and Supplies | unit | 22 | 1.00 | 3185.28 | **70076.16** | |
| **Transportation Total:** | | | | | | **5610652.88** |
| Transportation | trip | 2122 | 497.00 | 5.32 | **5610652.88** | |
| **Workplace Assistance Total:** | | | | | | **19532276.00** |
| Workplace Assistance | hour | 632 | 1094.00 | 28.25 | **19532276.00** | |
| | | | | **GRAND TOTAL:** | | **623736860.71** |
| | | | | **Total Estimated Unduplicated Participants:** | | **7896** |
| | | | | **Factor D (Divide total by number of participants):** | | **78994.03** |
| | | | | **Average Length of Stay on the Waiver:** | | 349 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Services Total:** | | | | | | **1351039.33** |
| Adult Day Service - half day - Level 1 | half day | 26 | 191.00 | 25.19 | **125093.54** | |
| Adult Day Service - half day - Level 2 | half day | 54 | 252.00 | 33.05 | **449744.40** | |
| Adult Day Service - half day - Level 3 | half day | 86 | 226.00 | 39.35 | **764806.60** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Adult Day Service - 1/4 hour - Level 1 | 1/4 hour | 1 | 2129.00 | 1.58 | **3363.82** | |
| Adult Day Service - 1/4 hour - Level 2 | 1/4 hour | 1 | 1409.00 | 2.07 | **2916.63** | |
| Adult Day Service - 1/4 hour - Level 3 | 1/4 hour | 1 | 2079.00 | 2.46 | **5114.34** | |
| **Prevocational Services Total:** | | | | | | **1902899.40** |
| Prevocational Services (8:1) | hour | 146 | 751.00 | 6.89 | **755460.94** | |
| Prevocational Services (10:1) | hour | 123 | 497.00 | 5.51 | **336831.81** | |
| Prevocational Services (12:1) | hour | 147 | 809.00 | 4.59 | **545856.57** | |
| Prevocational Services (14:1) | hour | 74 | 443.00 | 3.92 | **128505.44** | |
| Prevocational Services (16:1) | hour | 69 | 574.00 | 3.44 | **136244.64** | |
| **Rent and Food for Unrelated Live-in Caregiver Total:** | | | | | | **29940.48** |
| Rent and Food for Unrelated Live-in Caregiver | month | 4 | 12.00 | 623.76 | **29940.48** | |
| **Residential Habilitation and Support Total:** | | | | | | **558819294.62** |
| Residential Habilitation and Support - 35 hours or less/week | hour | 2333 | 1022.00 | 27.17 | **64782137.42** | |
| Residential Habilitation and Support - Over 35 hours/week | hour | 5188 | 4255.00 | 22.38 | **494037157.20** | |
| **Respite Total:** | | | | | | **4606742.64** |
| Respite Nursing Care (RN) | 1/4 hour | 7 | 948.00 | 8.94 | **59325.84** | |
| Respite Nursing Care (LPN) | 1/4 hour | 24 | 695.00 | 6.78 | **113090.40** | |
| Respite | hour | 840 | 184.00 | 28.69 | **4434326.40** | |
| **Supported Employment Follow Along Total:** | | | | | | **753952.47** |
| Supported Employment Follow Along - Tier 1 | month | 62 | 11.00 | 201.91 | **137702.62** | |
| Supported Employment Follow Along - Tier 2 | month | 55 | 11.00 | 403.81 | **244305.05** | |
| Supported Employment Follow Along - Tier 3 | month | 21 | 11.00 | 605.72 | **139921.32** | |
| Supported Employment Follow Along - Tier 4 | hour | 26 | 221.00 | 40.38 | **232023.48** | |
| **Occupational Therapy Total:** | | | | | | **33943.50** |
| Occupational Therapy | 1/4 hour | 5 | 342.00 | 19.85 | **33943.50** | |
| **Physical Therapy Total:** | | | | | | **1912.68** |
| Physical Therapy | 1/4 hour | 1 | 92.00 | 20.79 | **1912.68** | |
| **Psychological Therapy Total:** | | | | | | **3067.68** |
| Psychological Therapy - Family | 1/4 hour | 0 | 0.00 | 0.01 | **0.00** | |
| Psychological Therapy - Individual | 1/4 hour | 14 | 8.00 | 17.73 | **1985.76** | |
| Psychological Therapy - Group | 1/4 hour | 49 | 4.00 | 5.52 | **1081.92** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Speech /Language Therapy Total:** | | | | | | **26715.15** |
| Speech /Language Therapy | 1/4 hour | 5 | 257.00 | 20.79 | **26715.15** | |
| **Adult Foster Care Total:** | | | | | | **9632969.94** |
| Adult Foster Care Level 1 | day | 70 | 350.00 | 59.52 | **1458240.00** | |
| Adult Foster Care Level 2 | day | 179 | 342.00 | 86.83 | **5315558.94** | |
| Adult Foster Care Level 3 | day | 70 | 346.00 | 118.05 | **2859171.00** | |
| **Behavioral Support Services Total:** | | | | | | **21358397.34** |
| Behavior Support Services - Level 1 | 1/4 hour | 4379 | 8.00 | 20.58 | **720958.56** | |
| Behavior Support Services - Level 2 | 1/4 hour | 4379 | 229.00 | 20.58 | **20637438.78** | |
| **Community Based Habilitation - Group Total:** | | | | | | **4904490.34** |
| Community Based Habilitation - Group - (2:1) | hour | 483 | 85.00 | 14.95 | **613772.25** | |
| Community Based Habilitation - Group - (3:1) | hour | 531 | 87.00 | 9.97 | **460584.09** | |
| Community Based Habilitation - Group - (4:1) | hour | 1925 | 266.00 | 7.48 | **3830134.00** | |
| **Community Based Habilitation - Individual Total:** | | | | | | **8951342.40** |
| Community Based Habilitation - Individual | hour | 1656 | 195.00 | 27.72 | **8951342.40** | |
| **Community Transition Total:** | | | | | | **166568.04** |
| Community Transition | unit | 153 | 1.00 | 1088.68 | **166568.04** | |
| **Electronic Monitoring Total:** | | | | | | **2287111.68** |
| Electronic Monitoring | hour | 163 | 2784.00 | 5.04 | **2287111.68** | |
| **Environmental Modifications Total:** | | | | | | **552133.40** |
| Environmental Modifications - Install/Maintain | unit | 70 | 1.00 | 7885.34 | **551973.80** | |
| Environmental Modifications - Equipment/Assessment/Inspection | unit | 1 | 8.00 | 19.95 | **159.60** | |
| **Facility Based Habilitation - Group Total:** | | | | | | **5099270.91** |
| Facility Based Habilitation - Group (2:1) | hour | 425 | 332.00 | 16.94 | **2390234.00** | |
| Facility Based Habilitation - Group (4:1) | hour | 696 | 204.00 | 8.47 | **1202604.48** | |
| Facility Based Habilitation - Group (6:1) | hour | 755 | 194.00 | 5.65 | **827555.50** | |
| Facility Based Habilitation - Group ( 8:1) | hour | 877 | 183.00 | 4.23 | **678876.93** | |
| **Facility Based Habilitation - Individual Total:** | | | | | | **2574633.60** |
| Facility Based Habilitation - Individual | hour | 258 | 360.00 | 27.72 | **2574633.60** | |
| **Facility Based Support Services Total:** | | | | | | **6542091.20** |
| Facility Based Support Services | hour | 3217 | 992.00 | 2.05 | **6542091.20** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Family and Caregiver Training Total:** | | | | | | **31275.36** |
| Family and Caregiver Training | unit | 18 | 4.00 | 434.38 | **31275.36** | |
| **Intensive Behavior Intervention Total:** | | | | | | **6646479.48** |
| Intensive Behavior Intervention - Level 1 | hour | 244 | 57.00 | 116.07 | **1614301.56** | |
| Intensive Behavior Intervention - Level 2 direct care staff | hour | 244 | 744.00 | 27.72 | **5032177.92** | |
| **Music Therapy Total:** | | | | | | **892871.28** |
| Music Therapy | 1/4 hour | 476 | 153.00 | 12.26 | **892871.28** | |
| **Personal Emergency Response System Total:** | | | | | | **89142.84** |
| Personal Emergency Response System | unit/month | 193 | 9.00 | 51.32 | **89142.84** | |
| **Recreational Therapy Total:** | | | | | | **305760.00** |
| Recreational Therapy | 1/4 hour | 130 | 196.00 | 12.00 | **305760.00** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **75825.71** |
| Specialized Medical Equipment and Supplies | unit | 23 | 1.00 | 3296.77 | **75825.71** | |
| **Transportation Total:** | | | | | | **5985182.40** |
| Transportation | trip | 2190 | 496.00 | 5.51 | **5985182.40** | |
| **Workplace Assistance Total:** | | | | | | **20799347.68** |
| Workplace Assistance | hour | 652 | 1091.00 | 29.24 | **20799347.68** | |
| | | | | **GRAND TOTAL:** | | **664424401.55** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8148** |
| | | | | **Factor D (Divide total by number of participants):** | | **81544.48** |
| | | | | **Average Length of Stay on the Waiver:** | | 348 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (9 of 9)

### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Services Total:** | | | | | | **1436622.63** |
| Adult Day Service - half day - Level 1 | half day | 27 | 192.00 | 26.07 | **135146.88** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Adult Day Service - half day - Level 2 | half day | 55 | 253.00 | 34.21 | **476032.15** | |
| Adult Day Service - half day - Level 3 | half day | 88 | 227.00 | 40.73 | **813622.48** | |
| Adult Day Service - 1/4 hour - Level 1 | 1/4 hour | 1 | 2135.00 | 1.64 | **3501.40** | |
| Adult Day Service - 1/4 hour - Level 2 | 1/4 hour | 1 | 1413.00 | 2.14 | **3023.82** | |
| Adult Day Service - 1/4 hour - Level 3 | 1/4 hour | 1 | 2085.00 | 2.54 | **5295.90** | |
| **Prevocational Services Total:** | | | | | | **2032393.38** |
| Prevocational Services (8:1) | hour | 151 | 753.00 | 7.13 | **810702.39** | |
| Prevocational Services (10:1) | hour | 126 | 498.00 | 5.70 | **357663.60** | |
| Prevocational Services (12:1) | hour | 151 | 811.00 | 4.75 | **581689.75** | |
| Prevocational Services (14:1) | hour | 76 | 444.00 | 4.06 | **137000.64** | |
| Prevocational Services (16:1) | hour | 71 | 575.00 | 3.56 | **145337.00** | |
| **Rent and Food for Unrelated Live-in Caregiver Total:** | | | | | | **30988.32** |
| Rent and Food for Unrelated Live-in Caregiver | month | 4 | 12.00 | 645.59 | **30988.32** | |
| **Residential Habilitation and Support Total:** | | | | | | **596922687.80** |
| Residential Habilitation and Support - 35 hours or less/week | hour | 2401 | 1025.00 | 28.12 | **69204023.00** | |
| Residential Habilitation and Support - Over 35 hours/week | hour | 5340 | 4267.00 | 23.16 | **527718664.80** | |
| **Respite Total:** | | | | | | **4918157.90** |
| Respite Nursing Care (RN) | 1/4 hour | 8 | 951.00 | 9.25 | **70374.00** | |
| Respite Nursing Care (LPN) | 1/4 hour | 25 | 697.00 | 7.02 | **122323.50** | |
| Respite | hour | 865 | 184.00 | 29.69 | **4725460.40** | |
| **Supported Employment Follow Along Total:** | | | | | | **795199.93** |
| Supported Employment Follow Along - Tier 1 | month | 63 | 11.00 | 208.97 | **144816.21** | |
| Supported Employment Follow Along - Tier 2 | month | 56 | 11.00 | 417.95 | **257457.20** | |
| Supported Employment Follow Along - Tier 3 | month | 22 | 11.00 | 626.92 | **151714.64** | |
| Supported Employment Follow Along - Tier 4 | hour | 26 | 222.00 | 41.79 | **241211.88** | |
| **Occupational Therapy Total:** | | | | | | **35226.10** |
| Occupational Therapy | 1/4 hour | 5 | 343.00 | 20.54 | **35226.10** | |
| **Physical Therapy Total:** | | | | | | **1979.84** |
| Physical Therapy | 1/4 hour | 1 | 92.00 | 21.52 | **1979.84** | |
| **Psychological Therapy Total:** | | | | | | **3344.00** |
| Psychological Therapy - Family | 1/4 hour | 0 | 0.00 | 0.01 | **0.00** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Psychological Therapy - Individual | 1/4 hour | 15 | 8.00 | 18.35 | **2202.00** | |
| Psychological Therapy - Group | 1/4 hour | 50 | 4.00 | 5.71 | **1142.00** | |
| **Speech /Language Therapy Total:** | | | | | | **27760.80** |
| Speech /Language Therapy | 1/4 hour | 5 | 258.00 | 21.52 | **27760.80** | |
| **Adult Foster Care Total:** | | | | | | **10281428.48** |
| Adult Foster Care Level 1 | day | 72 | 351.00 | 61.61 | **1557007.92** | |
| Adult Foster Care Level 2 | day | 184 | 343.00 | 89.87 | **5671875.44** | |
| Adult Foster Care Level 3 | day | 72 | 347.00 | 122.18 | **3052545.12** | |
| **Behavioral Support Services Total:** | | | | | | **22852855.20** |
| Behavior Support Services - Level 1 | 1/4 hour | 4508 | 8.00 | 21.30 | **768163.20** | |
| Behavior Support Services - Level 2 | 1/4 hour | 4508 | 230.00 | 21.30 | **22084692.00** | |
| **Community Based Habilitation - Group Total:** | | | | | | **5238966.06** |
| Community Based Habilitation - Group - (2:1) | hour | 497 | 85.00 | 15.48 | **653952.60** | |
| Community Based Habilitation - Group - (3:1) | hour | 547 | 87.00 | 10.32 | **491118.48** | |
| Community Based Habilitation - Group - (4:1) | hour | 1981 | 267.00 | 7.74 | **4093894.98** | |
| **Community Based Habilitation - Individual Total:** | | | | | | **9538707.75** |
| Community Based Habilitation - Individual | hour | 1705 | 195.00 | 28.69 | **9538707.75** | |
| **Community Transition Total:** | | | | | | **176904.46** |
| Community Transition | unit | 157 | 1.00 | 1126.78 | **176904.46** | |
| **Electronic Monitoring Total:** | | | | | | **2448472.32** |
| Electronic Monitoring | hour | 168 | 2792.00 | 5.22 | **2448472.32** | |
| **Environmental Modifications Total:** | | | | | | **587780.88** |
| Environmental Modifications - Install/Maintain | unit | 72 | 1.00 | 8161.33 | **587615.76** | |
| Environmental Modifications - Equipment/Assessment/Inspection | unit | 1 | 8.00 | 20.64 | **165.12** | |
| **Facility Based Habilitation - Group Total:** | | | | | | **5443409.82** |
| Facility Based Habilitation - Group (2:1) | hour | 438 | 333.00 | 17.53 | **2556820.62** | |
| Facility Based Habilitation - Group (4:1) | hour | 716 | 204.00 | 8.77 | **1280981.28** | |
| Facility Based Habilitation - Group (6:1) | hour | 777 | 194.00 | 5.85 | **881817.30** | |
| Facility Based Habilitation - Group ( 8:1) | hour | 903 | 183.00 | 4.38 | **723790.62** | |
| **Facility Based Habilitation - Individual Total:** | | | | | | **2744628.85** |
| Facility Based Habilitation - Individual | hour | 265 | 361.00 | 28.69 | **2744628.85** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Facility Based Support Services Total:** | | | | | | **6977204.08** |
| Facility Based Support Services | hour | 3311 | 994.00 | 2.12 | **6977204.08** | |
| **Family and Caregiver Training Total:** | | | | | | **34168.84** |
| Family and Caregiver Training | unit | 19 | 4.00 | 449.59 | **34168.84** | |
| **Intensive Behavior Intervention Total:** | | | | | | **7119037.80** |
| Intensive Behavior Intervention - Level 1 | hour | 252 | 57.00 | 120.13 | **1725547.32** | |
| Intensive Behavior Intervention - Level 2 direct care staff | hour | 252 | 746.00 | 28.69 | **5393490.48** | |
| **Music Therapy Total:** | | | | | | **951369.30** |
| Music Therapy | 1/4 hour | 490 | 153.00 | 12.69 | **951369.30** | |
| **Personal Emergency Response System Total:** | | | | | | **95137.92** |
| Personal Emergency Response System | unit/month | 199 | 9.00 | 53.12 | **95137.92** | |
| **Recreational Therapy Total:** | | | | | | **323764.56** |
| Recreational Therapy | 1/4 hour | 133 | 196.00 | 12.42 | **323764.56** | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **81891.60** |
| Specialized Medical Equipment and Supplies | unit | 24 | 1.00 | 3412.15 | **81891.60** | |
| **Transportation Total:** | | | | | | **6388189.50** |
| Transportation | trip | 2255 | 497.00 | 5.70 | **6388189.50** | |
| **Workplace Assistance Total:** | | | | | | **22213079.24** |
| Workplace Assistance | hour | 671 | 1094.00 | 30.26 | **22213079.24** | |

| | |
|---|---|
| **GRAND TOTAL:** | **709701357.36** |
| **Total Estimated Unduplicated Participants:** | **8388** |
| **Factor D (Divide total by number of participants):** | **84609.13** |
| **Average Length of Stay on the Waiver:** | 349 |